Proceedings

GOVERNOR'S SECOND CONFERENCE ON THE HANDICAPPED

Bloomington, Indiana
October 10-11, 1962

Foreword

A highly successful conference on the handicapped was held at Indiana University, Bloomington, Indiana, October 10 and 11, 1962. It was the second conference of its kind to be held in Indiana and the foundation for its success was built in May of 1961 when the Governor's First Conference on the Handicapped convened, delineated problem areas, and made recommendations concerning the solution to a number of problems.

Recognizing the complexity of problems which confront the handicapped citizen, Governor Matthew E. Welsh called the first statewide conference in order to achieve broader coordination of effort among the agencies and individuals who concern themselves with this matter.

The second conference was utilized to "chart a course" for the future of rehabilitation in Indiana, and the proceedings of the second conference contained herein, clearly reveal that all who are involved with this important activity are making a sincere and dedicated effort to fulfill their responsibility.

The Indiana State Board of Health and the Commission for the Handicapped herewith present the Proceedings of the Governor's Second Conference on the Handicapped.

A. C. Offutt, M.D.
State Health Commissioner
Indiana State Board of Health
Indianapolis

PROCEEDINGS OF THE

GOVERNOR'S SECOND CONFERENCE ON THE HANDICAPPED

October 10-11, 1962

INDIANA MEMORIAL UNION BUILDING
INDIANA UNIVERSITY
Bloomington, Indiana

Charting a Course

THE COMMISSION FOR THE HANDICAPPED

Neal E. Baxter, M.D., *Chairman*
Bloomington, Indiana

Ralph N. Phelps, *Vice-Chairman*
Indianapolis, Indiana

Theodore Dombrowski, *Secretary*
Executive Secretary, Lake County Society for Crippled Children and Adults
Gary, Indiana

Ralph Biery
Business Representative, AFL-CIO
Dayton, Indiana

Gayle S. Eads, Director
Division of Vocational Rehabilitation
State Department of Public Instruction
Indianapolis, Indiana

Joseph W. Elbert, D.O.
Petersburg, Indiana

Stewart T. Ginsberg, M.D.
Mental Health Commissioner
Department of Mental Health
Indianapolis, Indiana

Frank McKinley Hall, M.D.
Medical Director
State Department of Public Welfare
Indianapolis, Indiana

Paul H. Hoge
Director, Division of Parole
Department of Correction
Indianapolis, Indiana

Howard G. Lytle, Director
Indianapolis Goodwill Industries
Indianapolis, Indiana

Ralph E. McDonald, D.D.S.
Indiana University School of Dentistry
Indianapolis, Indiana

Tony C. Milazzo, Director
Division of Special Education
State Department of Public Instruction
Indianapolis, Indiana

Rutherford B. Porter, Ed.D.
Director, Department of Special Education
Indiana State College
Terre Haute, Indiana

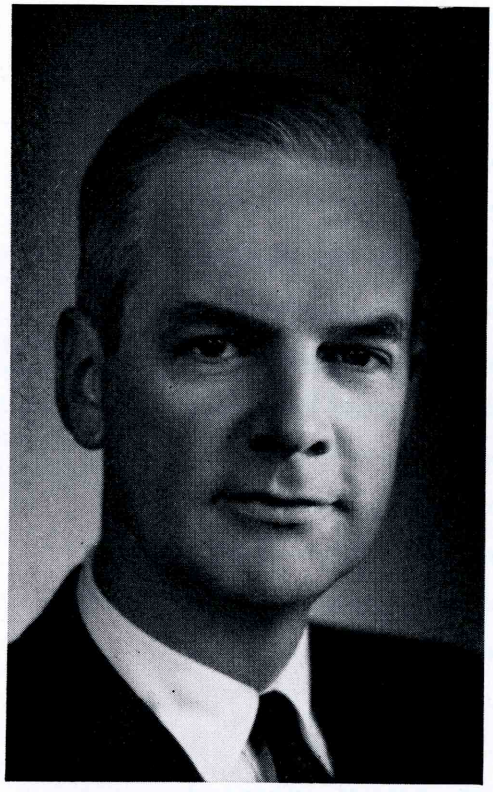
Alexander T. Ross, M.D.
Chairman, Department of Neurology
Indiana University School of Medicine
Indianapolis, Indiana

Aare Truumaa, Ph.D.
Chief Psychologist
Children's Outpatient and Consultation Services
Indiana University Medical Center
Indianapolis, Indiana

Mrs. Carolyn C. Tucker
Director of Public Relations and Special Events
Crossroads Rehabilitation Center
Indianapolis, Indiana

Executive Secretary
Charles E. Henley, Director
Division for the Handicapped
Indiana State Board of Health
Indianapolis, Indiana

THE GOVERNOR'S SECOND CONFERENCE ON THE HANDICAPPED



Matthew E. Welsh, *Governor*
State of Indiana

". . . we have full faith that Indiana will rise to its responsibilities in extending full opportunity to its disabled." Mary Switzer, The Governor's First Conference on the Handicapped, 1961.

Contents—

THE PROGRAM

Wednesday, October 10, 1962

Morning

9:30 Registration—Conference Lounge
Coffee Hour—East Lounge

10:30 First General Session — Whittenberger Auditorium, Louis W. Spolyar, M.D., Presiding
Invocation — Reverend Joseph Walker, First Presbyterian Church, Bloomington
Welcome—Neal E. Baxter, M.D.
Welcome—Elvis J. Stahr jr., LL.D.
Speaker: John J. Lee, Ph.D.
Address: Extending and Improving Programs and Services for the Handicapped

11:30 Luncheon—The Frangipani Room
Ralph N. Phelps, Presiding
Program: Presentation of brief reports regarding progress or changes since the 1961 Governor's Conference by:
The Commission for the Handicapped
Division of Vocational Rehabilitation
Special Education Division
Department of Mental Health
Department of Public Welfare
Employment Security Division
Veterans Administration
Bureau of Special Institutions, State Board of Health

Afternoon

2:00 to 4:30
Special Group Meetings on subjects of current interest and importance in Indiana's total program for the handicapped.

I. Workmen's Compensation
Whittenberger Auditorium
Kenneth I. Chapman, Session Chairman

II. Employment of the Handicapped Room G 45
Charles F. Gross, Session Chairman

III. Architectural Barriers Room G 41-43
M. O. Jeglum, Session Chairman

IV. Community Coordination and Planning for the Handicapped Room G 40-42
Robert Yoho, H.S.D., Session Chairman

V. Independent Living G 15
Nathan Salon, M.D., Session Chairman

VI. Education of the Handicapped Room G 44-46
Tony C. Milazzo, Session Chairman

Evening

6:00 Governor's Banquet—Frangipani Room
Neal E. Baxter, M.D., Presiding
Invocation — Reverend Ellison Cole, Trinity Episcopal Church, Bloomington
Introduction of the Commission for the Handicapped and Guests

7:00 *Speaker:* E. B. Whitten
Address: The Merging Streams in Rehabilitation

7:30 Presentation of Governor's Awards
The Honorable Matthew E. Welsh, Governor of Indiana

Thursday, October 11, 1962

Morning

9:00 to 11:00
Special Interest Group Sessions
The following organizations have accepted an invitation from the Commission for the Handicapped to meet at this time. Following is a summary of the special interest sessions developed by these groups:

1. American Cancer Society, Indiana Division Room G 44-66
   a. Demonstration of Esophageal Speech—Dr. Mary Mann

b. Address: "Purpose of the International Association for Laryngectomees"—Mr. I. E. Tenholder
c. Summary: "The Hopeful Side of Cancer" — Dr. Robert P. Acher
d. Film: "The Living Symbol" — Produced by WTHI-TV, Terre Haute

(Meeting open to all interested persons)

2. The National Foundation — March of Dimes Room G 40-42
   a. Presentation: The program of Birth Defects Special Treatment Center, Indiana University Medical Center
   b. Talk and Slides: "Work with Birth Defective Patients" — Dr. Robert F. Heimburger

   (Meeting open to all interested persons)

3. Indiana Society for Crippled Children and Adults, Inc.
   a. Business Meeting
   b. Informal meeting by members and friends with Mrs. Louise J. Lake, Consultant with the National Society for Crippled Children and Adults, Inc.

4. Indiana Epilepsy Society, Inc. Room G 15

   Topic: "Social Rehabilitation of the Epileptic, with the Possibility of the Psychological Overlay and Medical Prognosis"
   (1) Community Responsibility
   (2) Agency Referral
   (3) Medical and Social Related Problems

   (Meeting open to all interested persons)

5. Indiana Association for Retarded Children Room G 45
   a. Review of Indiana's Program for the Mentally Retarded Adult
   b. Discussion regarding recent trends in sheltered workshops and their relationship to state and local agencies
   c. Discussion of recruitment of workshop personnel

   (Meeting open to all interested persons)

6. Indiana Association for the Deaf Room 300 B
   a. Panel Discussion Topic: "The Needs of the Adult Deaf"

   (Meeting open to all interested persons)

7. Indiana Chapter Myasthenia Gravis Foundation Room 500 A
   a. Two films will be shown; one from the Myasthenia Gravis Foundation, and one from the Myasthenia Gravis Clinic of the Indiana University Medical Center
   b. A panel discussion

   (Meeting open to all interested persons)

8. Indiana Society for the Prevention of Blindness Room 300 A
   a. Discussion of Glaucoma Screening Clinic
   b. Discussion of Vision Screening

   (Meeting open to all interested persons)

11:30 Luncheon—Frangipani Room

Alex T. Ross, M.D., Presiding

Symposium—Presentations of topics discussed in group sessions including any conclusions or recommendations from these groups:

Workmen's Compensation Law — Kenneth I. Chapman

Employment of the Handicapped — Charles F. Gross

Architectural Barriers—Ralph Werking

Community Coordination and Planning for the Handicapped—Robert Yoho, H.S.D.

Independent Living—Nathan Salon, M.D.

Education of the Handicapped—Tony C. Milazzo

Conference Adjournment—Dr. Baxter

CONFERENCE DIRECTORY

Speakers

The Honorable Matthew E. Welsh
Governor, State of Indiana

John J. Lee, Ph.D.
Chairman, Department of Special Education and Vocational Rehabilitation
Wayne State University
Detroit, Michigan

E. B. Whitten, Executive Director
National Rehabilitation Association
Washington, D. C.

Elvis J. Stahr jr., LL.D.
President, Indiana University
Bloomington, Indiana

Presiding Officers

Neal E. Baxter, M.D.
Chairman, Commission for the Handicapped
Bloomington, Indiana

Ralph N. Phelps
Vice Chairman, Commission for the Handicapped
Indianapolis, Indiana

Alexander T. Ross, M.D.
Chairman, Program Committee
Commission for the Handicapped
Indianapolis, Indiana

Louis W. Spolyar, M.D.
Director, Bureau of Preventive Medicine
Indiana State Board of Health
Indianapolis, Indiana

Session Chairmen

Kenneth I. Chapman
Secretary for Health
Community Service Council of Metropolitan Indianapolis
Indianapolis, Indiana

Charles F. Gross, Chief
Employment Service
Employment Security Division
Indianapolis, Indiana

M. O. Jeglum, Executive Director
Indiana Society for Crippled Children and Adults, Inc.
Indianapolis, Indiana

Robert Yoho, H.S.D.
Director, Bureau of Public Health, Education, Records and Statistics
Indiana State Board of Health
Indianapolis, Indiana

Nathan Salon, M.D.
Governor's Commission on Aging and Indiana State Medical Association, Committee on Aging
Fort Wayne, Indiana

Tony C. Milazzo, Director
Division of Special Education
State Department of Public Instruction
Indianapolis, Indiana

Resource Persons

Workmen's Compensation Session

John A. Hetherington, M.D.
Chairman, Marion County Advisory Committee for Rehabilitation
Indianapolis

John Norris
Representative
Indiana State AFL-CIO
Indianapolis

Norman J. Beatty
General Council
Indiana Manufacturers Association
Indianapolis

Spiro B. Mitsos, Ph.D.
Director, Rehabilitation Center
Evansville

Geoffrey Segar
Attorney at Law
Indianapolis

Freeman Ketron
Chief, Guidance, Training and Counseling
Division of Vocational Rehabilitation
Indianapolis

Joe Miller, Chairman
Indiana Workmen's Compensation Laws Recodification Committee
Indianapolis

Employment of the Handicapped Session

Edmond J. Leonard
Acting Director of Information
The President's Committee on Employment of the Handicapped
Washington, D.C.

Harlan J. Noel
Representative
Indiana State AFL-CIO
Indianapolis

Harold Schuman
General Manager
Indiana Manufacturing Association
Indianapolis

Howard G. Lytle
Executive Director
Indianapolis Goodwill Industries
Indianapolis

Architectural Barriers Session

Bert J. Westover, Director and Secretary
Indiana Administrative Building Council
Indianapolis

Don E. Gibson, Executive Secretary
The Indiana Society of Architects
Indianapolis

Mrs. Louise Lake
Field Director on Architectural Barriers
National Society for Crippled Children and Adults, Inc.
Chicago, Illinois

Special Education Session

Jean Anderson, Supervisor
Programs for Speech and Hearing
Division of Special Education
Indianapolis

Leslie Brinegar, Supervisor
Programs for Mentally Retarded
Division of Special Education
Indianapolis

Independent Living Session

Margaret Warner
Health Education Consultant
Indiana State Board of Health
Fort Wayne

Malcolm Mason, Director
Division of Health and Physical Education
Indiana State Board of Health
Indianapolis

Helen Daniels
Central Services Consultant
Community Service Council of Metropolitan Indianapolis, Inc.

Community Coordination and Planning for the Handicapped Session

Gale E. Coons, Executive Secretary
Indiana State Dental Association
Indianapolis

Clotilde Sanguinet, Executive Secretary
Indiana Health Careers, Inc.
Indianapolis

Lucretia Saunders
Indiana State Board of Health
Indianapolis

MAJOR ADDRESSES

Dr. Baxter's Welcoming Remarks

IN MAY OF 1961, the Governor's First Conference on the Handicapped was held here in this same setting. That meeting was attended by more than 350 persons representing all areas of rehabilitation and the response to the conference indicated that most of those in attendance believed that there was a real need for this kind of "across the board" meeting.

The need for better coordination and cooperation among agencies, professions, and all others interested in the handicapped is becoming more and more apparent. We realize that we cannot do a really good job in our own setting unless we know what is happening in other places. The first step in building a more coordinated program, is to become better acquainted.

This process of becoming better acquainted was started last year. It will continue at this conference, of course, and in addition to this important activity we now begin more specific work. We are here to "chart a course" for the future of rehabilitation in Indiana. We believe we have a good program. We believe real concrete proposals will be forthcoming from this, the Governor's Second Conference on the Handicapped.

It is with great pleasure that, on behalf of the Governor and the Commission for the Handicapped, I welcome you to this conference.

Following is an abstract of the keynote address by John J. Lee, Ph.D., Chairman, Department of Special Education and Vocational Rehabilitation, Wayne State University, Detroit, Michigan.

"Extending and Improving Programs and Services for the Handicapped"

Dr. John J. Lee from Wayne State University, in keynoting the Governor's Second Annual Conference on the Handicapped in Bloomington, on October 10, emphasized the theme of the Conference which was *To Chart A Course.*

He first pointed up that both public and private agencies share the same common objectives, have the same common tasks, serve the same people, and have the same kinds of resources of money, people and knowledge to work with. He distinguished however, that public agencies tend to center on direct services which must be universal and are citizen's rights and receive tax support. He differentiated that private agencies, which in the United States last year received and expended some eight billion dollars, may provide direct services—should supplement but not duplicate the services of public agencies; do not have the obligation of universality; may emphasize experimentation and research, and have the obligation to support public agency programs.

Through the combination of public and private agencies our precedent concern should be to prevent illness, disability and dependency. Our succeeding obligations are to provide care, treatment, education and rehabilitation to alleviate suffering and to reduce dependency. Education, health, religion, and welfare supported through private agencies supported by contributions to them are exempt from taxation may be defined as the four bright jewels in American democracy. Dr. Lee indicated that in our areas we can just about measure the advancement of a culture and evaluate the character of the people by the kind and extent of provisions that are made for the prevention, care, treatment, education and rehabilitation of the handicapped.

In *Charting a Course,* Dr. Lee indicated that our first *authority* is the authority *need.* That authority is a composite growing out of the total needs of all of our ill and handicapped from birth throughout their lifetimes. He defined the second kind of authority as *knowledge* which controls all that we know and all that we can do to prevent disability and to provide care, treatment, education and rehabilitation.

The third kind of *authority* he defined was the authority of *profession.* It involves all of the specialist personnel and their qualifications of knowledge, competencies and skills. It involves the level of their professionalization, how many there are and where they are. It seems that no where do we have enough professionals to meet the demands of "Need."

The next kind of *authority* is the authority of *Social Organization.* It includes all our public and private agencies, the legal and statutory provisions affecting public agencies and the incorporation and by-laws which authorize or limit private agencies. These provisions may be constitutional or statutory, may be rules and regulations, they may involve precedents or may be discretionary. The issue is are they creative and adequate or are they restricting and defeating.

The fifth *authority* affecting all these programs is the authority of *position* of the persons responsible for organizing and implementing every phase of our programs, of assisting all personnel in their most creative efforts and of securing the resources, whether of tax support or citizen beneficence. As we perfect this authority it will be power "for," "with," and "through" people, rather than authority "over" people.

The final *authority* is the authority of *resources.* That's what we have to work with in designing all of our programs and putting them into effect. He said everyone of these "authorities" is critical and controlling. Let any one of them lag or be limited and human need will continue to go un-met.

In pointing the efforts of the conferees in relation to the conference's demand of *Charting the Course,* Dr. Lee told the delegates they were engaged in an enterprise to determine what responsibilities should be left to handicapped individuals and their families, what programs and resources should be the responsibility at local levels, what responsibilities should devolve upon public and private agencies at state levels and at national levels.

In pointing up the seriousness of the challenge which confronts our public and private agencies in the years ahead he pointed to this social trend —that tremendous social forces are combined and are rapidly forcing rising thresholds in employability. These forces he named as automa-

tion, specialization, technology, professionalism, urbanization, personnel selection, evaluation procedures, employment fringe benefits, seniority provisions, minimum wage and hour laws etc., etc. He indicated that unless our combined programs can be effective first, to prevent disability, and, second, to provide care, treatment, education and rehabilitation, a continually increasing number of our handicapped citizens will be unemployable with the resulting increase in burdens of dependency which will impede the total advance and well-being of all of our people.

The theme of this conference is, Dr. Lee said, most important social business.

Following is the text of the banquet address by E. B. Whitten, Executive Director, National Rehabilitation Association, Washington, D. C.

"Mobilizing the Community for Rehabilitation"

I have chosen to use as a topic for my talk tonight "Mobilizing the Community for Rehabilitation." Let us begin by defining the key words used in this topic. By "community" we mean "a body of people having common organization or interest and living in the same place under the same laws." Under this definition, an entire state might be considered a community, or some one geographical or political subdivision might be the community.

By "mobilize," we mean "to assemble and make ready for use."

We are interested, then, tonight, in how a body of people having common interests can be made ready for use in rehabilitating the handicapped.

Before we proceed, let us consider how people look at rehabilitation today. Then, maybe we can plan more effectively how we can make use of the general public in our future planning.

Many Americans look at rehabilitation as a fulfillment for handicapped people of the American dream of equality of opportunity.

The American really believes in equality of opportunity, as he understands it. He is for the underdog. Americans have waged a long, hard fight for political equality. They are still waging a battle for educational opportunity. The average American has fought against heavy odds for a modicum of social security. He believes that every man should have an opportunity to work. He does not believe that the handicapped should be excluded from the blessings of work. He, therefore, sees rehabilitation as an extension of equality of opportunity to the handicapped. So far as rehabilitation can be reduced to this simple idea, he is for it. In fact, he is like to regard rehabilitation as a *right* of disabled individuals. There is a lot of difference, too, between the "right" concept and the "beneficent government" concept, which up to this date we have nourished in this country.

When Mr. American looks at rehabilitation in his country, he sees some things he likes. For instance, he is pleased by what he sees going on in rehabilitation facilities. He is entranced by the sight of scores of severely handicapped people striving to achieve their own rehabilitation. He gets a real up-lift from case stories that he hears at his civic club. When he hears about the accomplishments of the state-federal program, he is glad his government supports such work. Then, too, he likes the rehabilitation people he knows. The physician, the counselor, the therapist, all of them, seem like real people, doing a real job. He firmly believes that they are a dedicated group. He notices that they live their work, both during formal work hours and after. He appreciates their zeal, their industriousness; most of all, he likes to see handicapped people at work. This is the real payoff, he thinks. Since he has probably been without a job sometime or other, he appreciates what the pay check means. The picture of the severely handicapped person receiving his first pay check means more to him, far more, than to many of us. In addition to the fact that he likes to support programs which bring economic and social benefits to his fellow man, he likes to be personally involved in doing something for someone else. He has accepted the concept of being his brother's keeper, although he may never have expressed it just this way. He particularly likes to feel that he has been helpful personally to a handicapped individual. He will really help to get his club or his chapter mobilized behind a plan to help with an individual rehabilitation case.

When he looks at rehabilitation, however, he is concerned about some things he sees. He is concerned with the difference between the numbers of handicapped individuals said to need rehabilitation and the numbers that are being rehabilitated. He wonders if there are really so many handicapped people after all. If this is the problem that people say it is, he cannot help wondering why rehabilitation programs, including those in his own state, are not further developed. We might add that his representative in Congress is also very much concerned about this. He cannot understand why some states and many local communities take so little interest in rehabilitation. He is worried by the fact that many states, including his own state, are allowing federal allotments to go unused, because state legislations do not appropriate enough money to match the federal funds that are available. Do the states, he asks, expect the federal government to carry the whole burden of rehabilitation? It may appear to him sometimes that they do, despite of all he hears about individual state and community responsibility. Why should a state or a local community, he asks, be less concerned about the rehabilitation of handicapped people than the federal government. He gets somewhat confused as he considers the gap between the needs, which he has no reason to doubt, and the steps taken to meet these needs.

In addition to these general concerns, some agency policies and procedures confuse him. He understands that laws are to be obeyed and that regulations are necessary in order to implement laws. But he wonders if it is necessary to be as technical about things as agencies sometime appear to be. Technicalities of eligibility confuse him. Technicalities of feasibility baffle him. He hears that individuals are being denied rehabilitation services because there does not appear to be a reasonable expectation that they will be employable after they receive such services. He wonders if agency representatives can really be smart enough to tell at the beginning whether a severely disabled person can be rehabilitated. Would it not be better, he wonders, if every handicapped individual was given the opportunity to demonstrate for himself how far he can go toward complete rehabilitation. He hears of people who have been considered unfeasible for rehabilitation but who are able to rehabilitate themselves without the help of official or voluntary rehabilitation agencies. Even if the individual cannot be fully rehabilitated to employment, would it not be good business to help him become as independent as possible of assistance from others. Why are some classes of disabled people receiving rehabilitation services, while other classes, equally disabled, are not? He understands, for instance, that programs for the orthopedically handicapped are well advanced. He hears that rehabilitation programs for the mentally ill, the mentally retarded, and the cerebral palsy are hardly more than in their infant stages.

He is frustrated by the many agencies that seem to be involved in rehabilitation. He is somewhat worried by the fact that the handicapped person is getting: public assistance from the welfare department, counseling from the family service association, counseling and training from the Vocational Rehabilitation Division, hospitalization in a state hospital, employment counseling and placement from an employment service office. Is it possible we are trying to divide the individual into too many small pieces? He hears rumors of the lack of coordination among the various public and voluntary agencies that have attempted to serve handicapped people. How much truth there is to this he doesn't know for sure, since he has no opportunity to really study the situation.

The professional aspects of rehabilitation are sometimes hard for him to understand. He believes, of course, that any one should be well trained to do the job he has to do. He sometimes wonders, however, whether too much attention is given to adance degrees. It is true, as he has heard, that the more training people get the fewer clients, or patients, they seem to serve. Do they sometimes become more concerned with the client-worker ratio than they are with the rehabilitation of the handicapped? On one occasion, he saw a rehabilitation team in action. Is it really necessary, he asks himself, to have a room full of people participating in staff conferences to discuss individual cases?

In his own business, staff conferences are held to a minimum, and every possible effort is made to concentrate upon the work that has to be done. He's not quite sure that business principles will apply in the rehabilitation setting, but it does look to him like team work is sometimes overdone. He can't help wondering if team work is just not another way of justifying getting everyone into the act. Despite these doubts, he likes rehabilitation, he believes in it, wants to support

it. Although worried, he is tolerant, reluctant to be critical.

If these statements fairly reflect the attitude of the average man toward rehabilitation, how shall he be approached by those who would like to "mobilize" the community for rehabilitation. In fairness to the people we want to help us, there are some principles we must bear in mind.

In the first place, we should have in mind an "ideal" situation toward which we are working. What is an ideal rehabilitation program for, in the community and for the nation? There are a few things that seem self-evident. Tax supported rehabilitation programs must be staffed and financed to provide a comprehensive rehabilitation service, when it is first needed. Efforts to provide rehabilitation services are often, too little and too late. A second requisite is a variety of voluntary rehabilitation activities which supplement the work of the official agencies, pioneer in areas of greatest need, and serve as a conscience of the community to remind it of its obligations. Together, public and voluntary agencies will offer maximum rehabilitation services to all the handicapped without regard to the nature and extent of their disability or their ages.

This type of rehabilitation program implies plenty of adequately trained professional people; physicians, counselors, social workers, employment specialists, psychologists, therapists, nurses, and so forth. It also implies the network of rehabilitation facilities wherein the combined skills of these professionals can be applied to needs of the disabled. A variety of different type facilities will be needed. They shall include the comprehensive rehabilitation center, the more limited rehabilitation center, the vocationally oriented center, rehabilitation workshops, workshops and evaluation centers, and extended employment workshops. It further implies financial support of the programs to the end of maximum utilization of professional skills and facilities are assured.

Next, having an ideal before us, we should see our individual efforts as a part of this total pattern of services. It is not often that we can mobilize a community to meet total needs. But we can mobilize to secure services that will fit into a pattern of total needs. When we do understand what we mean by rehabilitation and have agreed upon the kind of organization and services that we need in order to achieve our ends, and we have got to the point we can understand our own respective roles in the total rehabilitation picture, then we are in a position to turn to the community. How do we gain the cooperation of this community?

In the first place, we treat people as thinking adults. We have our facts mobilized. We know what we are talking about. We are as ready to discuss our weaknesses as we are our strengths. As willing to admit that we do not know everything as we are that we do not some things. We are frank about our programs. We acknowledge the fact that rehabilitation is big business and an expensive business. We recognize the possibility of recurring deficits and the need for seeking greater tax support. We appeal to our people on the basis of their good common sense as well as their humanitarian idealism. We enlist their help for big tasks, not for little ones.

As I conclude, you may be asking yourself how much more you know than before about mobilizing the community for rehabilitation. You may not know anymore. The actual process of community organization can be reduced almost to a formula. There are experts in this field. I am not one. You probably have some such individuals in your own agencies. If you do not you can hire them. Without discounting the value of their services, I would say that preparation of self to mobilize a community is as important, if not more so, then the actual technique of organization. If what I have said proves to be of any value it will be in causing leaders in the rehabilitation movement in Indiana to: 1) re-examine their motivations, 2) re-assess their objectives in the light of total needs for the handicapped, and 3) consider fully their obligations to the public to whom they look for support as well as to the handicapped people they serve.

There is no more difficult task to which we can dedicate ourselves than the rehabilitation of handicapped people. At the same time, there is no more rewarding cause on which we may expend ourselves than providing rehabilitation services to the handicapped people.

AGENCY REPORTS

The following are short reports regarding progress or change in State agency programs since the 1961 Conference on the Handicapped.

The Commission for the Handicapped

Neal E. Baxter, M.D.

Probably the most striking change to take place in the program of the Commission for the Handicapped since the Conference last year has been its affiliation with the President's Committee on Employment of the Handicapped. This development was the result of an executive order of the Governor on August 31, 1961, which gave the Commission the duties and responsibilities that had formerly been those of the Governor's Committee on Employment of the Handicapped.

The President's Committee is designed to promote the employment of the handicapped "by creating nationwide interest in rehabilitation and employment" of these citizens, and "by obtaining and maintaining cooperation from all public and private groups in the field." Its purpose can be stated briefly:

(1) To provide for a continuing program of public information and education for the employment of handicapped citizens, and

(2) To cooperate with all groups interested in the employment of the handicapped, including Government agencies, private groups, and individuals.

Since receiving this assignment the Commission has cooperated in the many activities of the President's Committee, including the distribution of films, news releases, spot announcements and literature regarding employment of the handicapped; directing the annual State essay contest in the high schools; participation in the national awards program, etc.

Two studies have been conducted by the Commission during the past year.

1. A State Rehabilitation Agency Survey was begun on February 1, 1961. The purpose of this survey is to gain some basic data concerning the present total program for the handicapped in Indiana. Survey forms were delivered to approximately 1300 agencies, schools, organizations, and other groups. The results are now being tabulated and a report should be available before the first of next year.
2. The Grant County Rehabilitation Study is being carried on by the State Board of Health and the Grant County United Fund for the purpose of determining the number of handicapped persons in that county and their rehabilitation needs.

Phase one of this study has been completed and a completed report of this project should also be ready by the first of the year. A preliminary progress report is available on the literature table near the registration desk.

Division of Special Education

Tony C. Milazzo

Early History

Before proceeding with the developments in educating handicapped children since the Governor's First Conference on the Handicapped it might be well to review the development of the state-wide special education program.

1927—Legislation was passed allowing local school corporations to establish special education programs for physically handicapped children; however, no funds for state support were provided nor was there provision for administration or supervision at the state level.

1947—Legislation was passed which actually represented the beginning of special education for the handicapped in Indiana.

It provided state funds for the support of special education programs for educable children who were physically and/or mentally handicapped operated by local school corporations.

It established the Division of Special Education and created the position of Director of this Division to be responsible for the administration and supervision of the state-wide program.

1955—Legislation was passed allowing for a group of children who were more severely mentally retarded than the original 1947 legislation had included.

In addition, the source of funds for state

support was amended to make more funds available.

1957—Legislation was passed to provide for two supervisory positions to be created in the Division of Special Education.

1961—Legislation was passed allowing for the inclusion of costs of special administration and psychological services for state reimbursement purposes.

Funds were also provided for an additional supervisory position to be established in the Division.

Status of the State-wide Special Education Program

The following figures indicate the numbers of counties operating special education programs, numbers of school corporations operating special education programs, numbers of special education personnel, and number of pupils enrolled in the various programs for school year 1961-62.

COUNTIES WITH PROGRAMS, PARTICIPATING SCHOOL CORPORATIONS, PUPILS, AND TEACHERS

	Counties With Programs	Participating Corporations	Pupils	Teachers
Crippled	18	19	686	50
Partially Sighted	6	7	135	11
Blind	3	4	24	4
Mentally Retarded	60	98	4,950	343
Deaf and Hard of Hearing	4	4	78	9
Speech and Hearing Therapy	53	95	23,444	197
Physical Therapy	5	7	274	12
Occupational Therapy	3	5	157	5
Homebound Instruction	82	266	1,110	747
School-Home Telephone	28	42	72	0
Special Transportation	44	144	378	0
Emotionally Disturbed	3	3	28	5
Combined Resource Program (B & PS)	1	1	13	1
Psychological Services	40	*57	0	0
Special Administration	7	**7	0	0

* This includes school corporations which employ school psychologists and/or school psychometrists on their staff as well as school corporations which contract for school psychological services.

** This figure represents 7 full or part-time directors of special education employed by 7 school corporations.

There were 30,551 pupils enrolled in public special education programs for 1961-62 and this represents an increase of approximately 1500 pupils. Despite this increase Indiana is still only meeting the needs of approximately 25% of these handicapped children who should be enrolled in programs. For the past 4 or 5 years Indiana has been meeting the needs of this same one-fourth despite a yearly increase of approximately 1500 children per year being newly enrolled in programs. The explanation seems to be that we are adding just enough programs to keep up with the increase in population.

Problems Relating to the Reason Indiana is Meeting the Needs of so Few Handicapped Children

A number of problems have influenced the discrepancy between the numbers of children being served and those in need of service. A few of the major problems include:

- Shortage of teachers and therapists
- Shortage of local directors and supervisors of special education
- Shortage of school psychologists and school psychometrists
- Insufficient college training programs in the state
- Shortage of state level consultative and supervisory personnel
- Inconsistencies in state reimbursement to local schools due to the existing reimbursement method
- Continued lack of community understanding

Developments in the Division Since Last Conference

A number of things have happened since the last Governor's Conference which should work toward the solving of some of the above mentioned problems. Some of these include:

Staff Addition—A Supervisor, Programs for

the Physically Handicapped was added to the Division.

Additional Reimbursable Services—Reimbursement is now available for approved psychological services and directors of special education employed by local schools.

Certification—All certification patterns in all areas of the handicapped have been revised and a certificate for local directors of special education has been developed.

Research—A study of the state reimbursement program and the philosophy behind it has been conducted by the Division of Special Education and a special Advisory Committee. Recommendations for legislation relating to the reimbursement method have been developed as a result.

A study of pupil progress of educable mental retardates as a function of age at which they were placed in special education classes is underway.

Experimental programs for emotionally disturbed.

Experimental program for brain-injured.

Experimental summer speech and hearing program.

Training—Public Law 85-926 has provided for two federal grants to be administered by the State Department of Public Instruction to be used for advanced training of local and state directors and supervisors of special education.

Agency Cooperation—Increased emphasis has been placed upon the cooperation of the various agencies and services in the serving of handicapped children and youth. Demonstrations of this include: a grant provided by the Department of Mental Health for the employment of a Supervisor, School Psychological Services in the Division of Special Education; Joint Conference held for teachers in residential school for the blind and the public day teachers of the visually handicapped; Cooperation with the Division of the Handicapped in the Grant County Survey of Handicapped; joint conference with Division on Mental Retardation concerning responsibilities for the severely mentally retarded; and other cooperative activities with such organizations and services as: Indiana Agency for the Blind, Division of Vocational Rehabilitation, Council for Exceptional Children, State Board of Health, Division on Mental Retardation, etc.

Department of Mental Health

Stewart T. Ginsberg, M.D.

Mental illness and mental retardation have been one of our major human problems. Serious mental illness affects one family in three. Three out of every hundred children born are mentally retarded. Ten in one hundred of our citizens will require hospital treatment for a mental disorder at some time during their lives.

There have been historic break-throughs during the long transition from the static concept of custodial care for our mentally ill to the present successful and gratifying treatment and rehabilitation achievements. Mental illness no longer is a stigma to be borne in despair, without hope; it is a sickness that can be treated effectively. The advances in treatment of the mentally ill which we can now provide, and intensive research give hope that we may yet attain a major break-through comparable in its human significance to that achieved for other medical illness.

However, the problem remains a major challenge to the state, the community, and the local voluntary agencies who provide care and treatment to increased numbers of mentally handicapped in our increasing population.

Long-term planning for mental health in Indiana is not new. Six studies and surveys have been conducted since 1953. The Department of Mental Health, on the recommendation of its Advisory Board, presented to the 91st and 92nd General Assembly comprehensive long-range plans, realistically based on pay-as-we-go recommendations. The Department of Mental Health has reviewed changing conditions and trends to develop this ten-year plan. The plan is flexible and will undoubtedly change with each future biennium to keep abreast of new developments in the multiple factors that will influence changing trends and requirements.

The Goals

1. To improve psychiatric care for all citizens.
2. To coordinate all responsible mental health resources and services, public and private, federal, state, and local into a program to serve the emotionally disturbed, mentally ill, mentally retarded, the alcoholic, and all other mentally handicapped of all age groups.
3. To increase research and training.

The Basis for a Long-Range Plan

The following factors must be considered in planning the future mental health program for the State:

1. The responsibility for the treatment of the mental patient is essentially the same as in other diseases. It rests first with the patient himself and his family, and his physician, then with non-governmental health agencies; if these are unable to fill the needs, the responsibility is spread to local, state, and federal government.
2. Population growth. 1950 — 3,934,200
   1960—4,662,500 1970—5,500,000
3. Changing trends in admissions to State mental hospitals and schools for the mentally retarded.
   a. Increased number of admissions.
      1950—2,358 1955—4,411
      1960—4,858 1962—4,988
   b. Increased number of children and teenagers admitted to mental hospitals.
      1950—56 1955—177 1961—318
   c. Decreased number of first admissions over age 65.
      1960—865 1961—820 1962—761
   d. Increased number of voluntary admissions, indicating greater acceptance of hospitalization.
      1950—0 1955—1,071
      1960—1,115 1962—1,459
4. Changing trends in hospital treatment.
   a. Improved treatment techniques.
   b. Improved rehabilitation techniques.
   c. Improved means of returning patients to the community.
   d. While admissions and enrollment increased, number of patients in hospitals decreased slightly:
      Present in hospitals: 1959—15,464
      1960—15,429 1961—15,308
   e. Increased number of volunteers serving mental patients.
5. Changing trends in release from State Mental hospitals and schools for the mentally retarded.
   a. Increased number of discharges.
      1950—1,014 1955—2,839
      1960—3,507 1962—3,747
      Of new admissions, 80% are discharged in 1 year. Even admissions of patients over 65 years of age show a discharge rate of 20%.
   b. Increased number of convalescent leaves.
      1950—0 1955—18,068
      1960—31,291 1962—37,145
   c. Increased number of patients placed in Family Care.
      1960—53 1962—184
   d. Increased number of aged patients released under provisions of Old Age Assistance.
      1962 (first year available)—45
6. Limitations of present institutions.
   a. Overcrowding, approximately 23%.
   b. Understaffing, approximately 50%.
   c. Many buildings, old and in poor repair.
   d. Many buildings, fire and safety hazards.
   e. Waiting lists.
      1955—464 1960—1,022
      1962—1,139
7. Increasing utilization of community resources for the emotionally disturbed, mentally ill, and mentally retarded.
   a. Increased number of community psychiatric clinics.
      1950— 4 1955— 7
      1960—14 1962—17
   b. Increased number of patients treated in community psychiatric clinics.
      1955—3,475 1960—6,174
      1962—8,880
   c. Increased psychiatric consultation service to other community agencies.
   d. Increased educational programs on mental health and mental illness.
   e. Increased number of mental patients treated in general hospitals.
      1961—7,092 (more than were admitted to State mental hospitals)
   f. Increased number of mentally ill and mentally retarded being cared for in nursing homes and county homes.
   g. Increased number of special facilities for

mentally retarded and emotionally disturbed children.

THE PLAN

1. For the Mentally Ill in the State Hospitals:
   a. Improve quality of treatment for all patients.
   b. Increase staffing and improve salary scales.
   c. Develop out-patient and follow-up services.
   d. Continue physical plant rehabilitation and replacement program.
   e. Release more patients on Family Care and through Old Age Assistance Program.
   f. Reduce the need for large mental hospitals.
2. For the Mentally Retarded:
   a. Expand facilities.
   b. Provide better care, treatment, and training.
   c. Continue relocation of Fort Wayne State School to new site.
   d. Construct new 200-bed hospital at Indiana University Medical Center.
   e. Establish a program of financial support for community services for the mentally retarded.
3. For the Emotionally Disturbed Child:
   a. Develop program of treatment for emotionally disturbed children in State hospitals.
   b. Construct residential treatment centers.
4. For the Alcoholic Patient:
   a. Increase number of clinics.
   b. Offer additional services to courts, hospitals, and other agencies.
   c. Expand educational program.
5. Community Services:
   a. Establish additional community psychiatric clinics.
   b. Establish centers for after-care for released mental patients.
   c. Coordinate State and local public and private agencies and services for more effective efforts to provide preventive measures, early recognition and evaluation, early treatment, and a broad scope of rehabilitation at the community level. Through these means, more patients will recover more quickly, and few will require State hospital care.
6. Appropriate funds for education and training.
7. Establish a State-financed research program in State mental hospitals.
8. Continue to cooperate with Indiana University School of Medicine and the State Universities, and with other State agencies in all ways that would be mutually helpful.

The task of caring for, treating, and rehabilitating the mentally disabled is a great responsibility and a great opportunity.

The opportunity is offered the State to provide new hope and new lives to many who would otherwise continue their existence in mental darkness and despair. It is also an opportunity for the State to develop a comprehensive program integrating all public and private, local, state, and federal resources and services to provide adequately for the mentally ill, the mentally retarded, the emotionally disturbed, and others in all age groups who are suffering from mental disabilities.

Indiana has been a leader in developing and providing an advanced and effective program of care, treatment, and rehabilitation of our mentally ill and mentally retarded. To maintain this position of leadership and to demonstrate our compassionate concern, we must continue to progress with imagination and new achievements.

The costs, great though they may be, actually reflect economies— the economy of providing intensive short-term treatment and returning patients to their homes more quickly, as contrasted with the more expensive long-term cost to the State for prolonged years spent by patients in mental hospitals; the economy in human values of preventing the tragedy of broken homes which result from prolonged illness; and the economy of using preventive maintenance to stop further deterioration of hospital buildings.

This comprehensive plan cannot be activated in its entirety at this time, but it does provide an important guide for action and for future efforts on behalf of the mentally disabled. Mentally retarded and mentally ill children, because of their unmet needs, receive special emphasis in these recommendations.

The budget for construction and rehabilitation submitted to the 93rd General Assembly lists in detail the requirements for the 1963-65 biennium and for subsequent biennia to fulfill a ten-year plan.

The personnel and operating budget for the 1963-65 biennium represents the expenditures required to implement the first phase of the long-range plan.

Each year that we fall behind, the more it will cost to catch up.

I urge all citizens to support this long-range program by helping to launch it in the 93rd General Assembly.

Bureau of Special Institutions
Indiana State Board of Health

Robert O. Yoho, H.S.D.

The duties of the Bureau of Special Institutions are to assist the State Health Commissioner in performing his duties as prescribed under Chapter 117 of the Acts of 1961. It shall further be the duty of this Bureau to insure that all the powers and duties of the Boards of Trustees of the various special institutions as are imposed upon the State Health Commissioner are preserved and carried out in accordance with Sec. 8 of the above-mentioned act.

The Bureau coordinates the activities of the chief administrative officers and staffs of the various special institutions and maintains administrative control of the institutions. The activities of the Bureau deal in detail with the general administrative work flow, coordination of program planning in the institutions, analyzing management program in each of the institutions, and such other duties as may be assigned from time to time.

Attached to the Bureau is a body known as the Commission for Special Institutions consisting of twelve members, six of whom are appointed by the Governor, and six of whom are appointed from the Advisory Committees assigned to each of the special institutions. This body is charged with advising the State Health Commissioner on the management of the special institutions covering matters pertaining to personnel, administration, medical care, and public relations.

The Commission for the Handicapped will, in all probability, be interested in only three of these special institutions at the present time, namely, the Indiana School for the Blind, the Indiana School for the Deaf, and the Indiana Agency for the Blind.

The Indiana School for the Blind has the constitutional responsibility of providing education to all blind children of the State of Indiana who may seek enrollment as its residential location at 7725 North College Avenue, Indianapolis. About the only entrance requirements for admission are that the child be legally blind, of sufficient mental capacity to benefit by the education offered by the School, and he adapt to residential school living.

The Indiana School for the Deaf has the constitutional responsibility of providing education to all deaf or hard-of-hearing children in the State of Indiana who may seek admission to its residential location at 1200 East Forty-Second Street, Indianapolis. There is no standard for determining deafness as legally deaf in a manner similar to that for determining the status of legally blind. The requirements for admission to the School for the Deaf are simply that the hearing of the child be so impaired that he cannot be expected to benefit from normal public school training, that he be educable, and that he be able to adjust to residential school living.

The Indiana Agency for the Blind, located at 536 West Thirtieth Street, Indianapolis, has been established as an organization for dealing with the adult blind. Its primary responsibility is vocational rehabilitation counseling and training. The organization actually provides a variety of services in addition to vocational rehabilitation. It operates a sheltered workshop which has some terminal employment features and provides home teacher services such as assisting in helping families adjust to blindness in the home.

The other institutions of the Bureau of Special Institutions do not have social adjustment and training of the handicapped as their primary responsibility. These institutions are the Indiana State Sanatorium, the Southern Indiana Tuberculosis Hospital, the Indiana Soldiers' and Sailors' Children's Home, and the Indiana State Soldiers' Home.

Both the Indiana State Sanatorium and the

Southern Indiana Tuberculosis Hospital deal with the treatment of the tuberculosis patient from a medical standpoint. No social adjustment of vocational rehabilitation training program is in progress or anticipated in the near future.

The Indiana State Soldiers' Home deals with the custodial housing of disabled and destitute veterans who, for the most part, are elderly patients. No handicapped program is in progress or contemplated in the near future.

The Indiana Soldiers' and Sailors' Children's Home is responsible for providing care and education to children of veterans who are otherwise unable to provide for their children. This institution does not provide a handicapped program and none is contemplated in the near future.

Vocational Rehabilitation Division

Gayle S. Eads

Vocational Rehabilitation is an old agency, having been established in 1923. It operates as a division of the Indiana State Department of Public Instruction on a state-federal funds basis, approximately 40% state, 60% federal.

I became director of this division on May 1, 1961. Any progress which we have made during the past year has been largely due to two things:

1. A hard core of dedicated and loyal career employees who were doing their jobs because they liked to rather than for the money they received.
2. The patience, helpfulness and understanding of our boss, State Superintendent William E. Wilson, who is in the audience today.

At present we are working with some 4000 cases encompassing a broad area of handicaps. These cases are served by the administrative office and 13 field offices which are located in key cities of the state.

I will mention, briefly, some of the things which we have done during the last year:

..... A 23% increase over 1960-61 in number of persons closed as rehabilitated.

..... A move from 51st place among the 54 states and territories, to 36th place in number of persons rehabilitated per 100,000 population.

..... A tie for ninth place among the 54 in numbers rehabilitated per counselor.

..... Initiated an in-service training program for all employees.

..... Employed a counselor for the deaf and hard of hearing, filling a position which has been open 5 years.

..... Moved 6 of 13 field offices to more suitable locations as leases expired.

..... Moved the VR Administrative office and the OASI Disability Determination Section (35 employees) into suitable quarters in the State House.

..... Employed and trained 8 new counselors, four as replacements, four as net increase in staff.

..... Emphasized placement of clients through joint meetings with Employment Security Division personnel, and the sending of 8 counselors through the E.S.D. interviewer induction training course of two weeks.

..... Received permission from the Office of the Budget to ask the legislature for sufficient funds to match offered federal funds. If such state appropriation is granted total funds would be 3½ times present budget.

It would be my hope that this division may have a head disposed to contrive, a heart to feel and a hand to execute all those things which may react to benefit the handicapped citizens of Indiana who may require our services.

Department of Public Welfare

Frank M. Hall, M.D.

Services for Crippled Children

A new South Bend Hospital Treatment Center was established by the State Department. The facility for the diagnosis and treatment of crippled children was authorized by the State Board of Public Welfare when Northern Indiana Children's Hospital was assigned to the Department of Mental Health by 1961 legislative action.

Plastic surgery has been added at the Fort Wayne Hospital Treatment Center. This has facilitated care of children in the Fort Wayne area. Also, it eliminated transportation problems involved in obtaining such care a long distance from home. Formerly children in need of plastic surgery had to be sent to Indianapolis. Fort

Wayne's Outpatient Clinics have been operating on a weekly basis since July 1, 1962.

Gary Hospital Treatment Center's professional staff has been increased by three additional Orthopedic Surgeons.

It is significant to note that the 1960 inpatient treatment care decreased by 3,504 hospital days. This reduction is a tremendous tax saving to Indiana's taxing units. Outpatient services, as well as the number of outpatient clinic visits, increased during 1961. This was brought about by the program's emphasis on the potentialities of crippled children's outpatient facilities at the five approved centers.

In summary, 70% of the crippled children's patient load for 1961 received only outpatient services, 26% received both inpatient and outpatient services and 4% received only inpatient care.

Services to the Blind and Aged

The 1961 amendments to the Welfare Act reduced residence requirements from 5 to 3 years out of the last 9 immediately preceding the date of application. Also a Federal Regulation made medical care retroactive for 90 days, if needed, prior to the month of application for all categorical public assistance programs.

Elderly persons living on marginal incomes were provided funds for health services only, even though they have sufficient resources for food, clothing and shelter.

A new phase of Old Age Assistance has been developed jointly with the Department of Mental Health for elderly persons found incapable of managing their estates or business affairs. The aim of the plan is to keep the senile person living in his home community by the appointment of a legal guardian.

Medical care for Incapacitated Parents in A D C

To implement legislation of the 87th Congress, the State Board of Public Welfare approved a resolution requiring that all County Medical Health Plans be amended to provide medical rehabilitative care for incapacitated parents living with recipient children. This action will strengthen the administration of Aid to Dependent Children by broadening rehabilitation resources for the physical restoration of ill parents.

Assistance to the Disabled

Effective January 1, 1963 Indiana will have in operation a fourth category of public assistance entitled Assistance to the Disabled. This program was established by Chapter 206, Acts of 1961 as an amendment to the Welfare Act.

Eligibility for assistance includes financial need, age of 18 years or more, and residence in the State of Indiana for a period of at least five years during the nine years immediately preceding the date of the filing of the application for assistance, the last year of which shall be continuous and immediately precede the date of application. There is no requirement regarding county residence.

The program recognizes the legal responsibility of parents, spouse, and other legal responsible relatives to support the applicant prior to use of public funds. The individual shall not have transferred property during the five years preceding the date of application for the express purpose of making himself eligible for assistance. The law does not provide for a lien against the property of the recipient but does provide that a claim is to be filed against the recipient's estate for all assistance granted. There is no citizenship requirement.

Applicants must be found to be disabled within the meaning of the law to be eligible for the benefits of the program. In determining disability, consideration must be given to the existence of a permanent impairment or a combination of such impairments, which together with such factors as age, training, skill, and working experience result in total disability.

The term "permanent" means a physical or mental impairment of major importance or a combination of such impairments which medical determination indicates is likely to continue throughout the lifetime of the individual and is not likely to respond to any known thereapeutic procedures. Permanent, however, does not rule out the possibility of rehabilitation, or even recovery from the disability. The term "permanent" is not used in the sense of everlasting or unchangeable, but is used as distinct from temporary or transient. The term "total" means the physical or mental impairment is such that the person is bedfast, or requires the help of another person to care for him because of his inability to carry on in his particular situation due to his disability.

The eligibility factor of disablement is determined by the Medical Review Team of the State Department on the basis of documented medical evidence furnished by a local examining physician. The Medical Review Team will consist of

a licensed physician and a medical social consultant.

All other factors of eligibility will be determined by the county department which agency is responsible for accepting and processing all applications.

The benefits of the program are a monthly grant of assistance not to exceed $70 plus medical care, based on need.

During the process of the medical study of each individual case, a determination will be made as to whether the individual's condition can be improved by treatment, thus providing opportunity for self-care and financial independence. All applicants will be expected to cooperate in any recommended treatment plan which may partially or wholly restore his physical or mental health.

Employment Security Division

Charles F. Gross

The Indiana Employment Security Division operates two major programs—Unemployment Insurance and Employment Service. Our services to the handicapped are measurable only under the Employment Service program.

In the Employment Service we attempt to provide assistance in finding employment opportunities for those individuals who come to us seeking such assistance. This service is provided through 31 local offices located in the more important communities throughout the state. On the first visit to a local office, the individual interested in assistance in finding employment, is registered for work. We call this "taking a new application." Some of these people have not made an occupational choice—don't know what kind of work they can or want to do—or because of some change in conditions are being forced to seek some new kind of work. Most such individuals are given employment counseling, a more intensive type of interviewing which permits us to delve more deeply into education, training, interests, aptitude, hobbies, and other leisure time activities. Through this means we attempt to assist the applicant in choosing a new or different vocation.

The counter-part of this is the service to employers in which we seek to determine the number and kinds of workers the employer needs in his establishment. The final step is the matching of the worker's abilities with the job requirements and our referral of qualified applicants for the employer's consideration.

During fiscal year 1962—the 12 month period ending June 30, 1962—we took new applications from 10,225 handicapped job seekers. Of this number, 3,089 received employment counseling. During the year we were able to fill 4,079 jobs in non-agricultural industries with handicapped persons.

In comparison with the previous fiscal year we were able to show some gain in these activities. The number of new applications of handicapped persons increased by 7 per cent. The number of handicapped individuals given employment counseling increased 29.7 per cent and the placement of handicapped workers showed a gain of 13.4 per cent.

While we are not satisfied with our service to handicapped applicants, we believe that we are able to take some pride in the fact they have received perhaps more consideration than non-handicapped, at least from a broad statistical standpoint. During fiscal year 1962, we took new work applications from 252,350 job seekers, provided counseling interviews for 21,619 of this number and filled 91,348 jobs in non-agricultural industries. For each thousand of all persons coming to us for assistance in the job market, we counseled 86 and recorded 362 placements. These ratios for the handicapped applicants, are 302 of each thousand were given counseling interviews and there were 399 placements.

Veterans Administration Regional Office

Noble C. Lehner

Mr. Phelps, Dr. Baxter, Ladies and Gentlemen:

It is a pleasure to represent the Veterans Administration and to participate in this Conference. I should say at the outset that the Veterans Administration has three hospitals and a Regional Office in Indiana; one hospital at Fort

Wayne, one at Marion, and two installations under the same direction in Indianapolis, in addition to the Regional Office. While all of the Veterans Administration activities in Indiana are interested to some degree or other in the rehabilitation of veterans, I am employed in the Regional Office and, as such, am representing the Vocational Rehabilitation phase of the Veterans Administration. We in the Regional Office have coordination functions with the hospitals and are aware of their rehabilitation activities, but, until a patient is actually released, have no direct responsibility for their vocational rehabilitation.

Many of you know of our work in assisting veterans with service connected disabilities adjust to these disabilities, vocationally speaking. We are continuing with this program, although as we get farther away from the wartime periods the numbers of cases are becoming smaller. Recent legislation has extended the period of time within which certain cases can receive training so that, although there are fixed terminal dates, these are some distance in the future. Certain blinded veterans, for example, may have until 1975 to complete vocational training. A year ago we were predicting rather dramatic decreases in our training load. There has been some decrease but we are still concerned with around one hundred active cases.

We are continuing to work with the children of deceased servicemen. These young people are assisted, both through counseling help and financial support, in their achievement of post-high school training. One point I should like to emphasize: the training need not be in college. It can be any bona-fide vocational course obtainable through resident school training. This includes trade and technical courses, beauty and barber training, etc. Home study and on-the-job or apprenticeship training are precluded. In this group there are a number of disabled and retarded individuals who need special attention. This is provided in the program and we make every effort to habilitate the educable and trainable among these.

Perhaps the most significant change in the program which I represent occurred last June when the activities of the Vocational Rehabilitation and Education Division in the Indianapolis Regional Office were consolidated with the Chicago Regional Office. This is part of a general consolidation program, designed to promote better efficiency and service. At present we are in the process of a similar consolidation, bringing the Wisconsin Vocational Rehabilitation and Education activities into the Chicago office. Counseling and training personnel have remained in the local areas to provide direct service to beneficiaries, while administrative and record keeping functions have been moved into Chicago.

In closing, I might say that we serve a rather specific, legally defined group. However, we are not self-sufficient and there has been and will continue to be constant need to call upon many of you and the agencies you represent for assistance in the solution of our problems. We have found these relationships to be mutually beneficial and I know that I speak for my colleagues in all phases of the Veterans Administration rehabilitation programs when I express our appreciation and hope that we may continue to work together.

DISCUSSION SESSION REPORTS

Architectural Barriers

Ralph B. Werking, Jr.

Although the discussion group was small, this is to be expected at the present time. The concept of architectural barriers is new to all of us. How many of us, when we came into this room, noticed that it is necessary to come down steps to get into the main part of the room? To most of us steps are not barriers, but to many handicapped individuals they are. The elimination of unnecessary barriers in the design of public buildings would be appreciated by the general public as a reasonable procedure in keeping with the times. To illustrate: the modern supermarket as compared to the old time store.

It was the consensus of the group that we need to take a positive approach in solving this problem of architectural barriers and to enlighten the public to the meaning of architectural barriers and to enlist their aid in carrying the ball.

It was suggested that architects be approached directly to enlist their assistance in making changes in existing building and in the preparation of plans for new ones.

It was the decision of the group that it be recommended that this body request of the Administration Building Council that the American Standard Specifications, dated October 31, 1961, as adopted by the American Standards Association, be included in their building regulations.

Workmen's Compensation

Kenneth T. Chapman

Discussion of the subject was lengthy and it is only possible to report the highlights.

1. No one disagreed with the concept that there should be provision for rehabilitation services in our Workmen's Compensation Laws.

2. It was suggested that, although the responsibility for providing benefits rests with the employer, some effort should be made to find a way whereby the employee can share responsibility for attaining the highest degree of success through rehabilitation.

3. Related to the factor of motivation, the value of early diagnosis and treatment was emphasized to prevent irreparable damage caused by delay due to litigation or other reasons.

4. It was also pointed out that the Recodification Committee is considering many of the points stressed in the letter to Lieutenant Governor Ristine and that there is allowance for rehabilitation services in the present law provided there is interest on the part of those individuals responsible to make these available. In many instances, insurance carriers have gone beyond the requirements of the law.

5. There was recognition on the part of the group that the 1915 law was passed to meet a social need and rehabilitation was unheard of at this time. Although efforts are now tending in the direction of restoring the individual, building provisions into the law for rehabilitation will be difficult.

6. Questions were raised as to the advisability of the State Compensation Agency assuming responsibility for rehabilitation. It appeared to be the consensus of the group that consideration should be given to established governmental agencies for providing these services.

7. Mr. E. B. Whitten pointed out that the workmen's compensation laws are on trial and they will be by-passed if ways and means are not found to resolve the problems inherent in administering them. In his opinion, the question of who needs rehabilitation and who decides this is the key to the whole question. He feels there should be a qualified staff within the framework of the Compensation Agency with the authority to supervise medical care by setting standards for personnel and facilities, acquiring complete data and following through on cases. No conclusions were reached on this point.

8. With an effective law and proper administration, it was felt that the injured worker would tend to be more cooperative in seeking the most favorable solution to his problem.

The group discussion of the Indiana Workmen's Compensation Laws was of value to the 24 participants (including the members of the panel) for the following reasons:

1. The group agreed that the Indiana Rehabilitation Association and the Governor's Commission for the Handicapped had taken a proper step in requesting that a legislative study committee be established out of the 1963 General Assembly to review the present compensation laws in Indiana. It went one step further in suggesting that the review be comprehensive rather than approaching selected features of the laws.

2. That the Indiana Rehabilitation Association and the Governor's Commission might consider ways and means of improving the channels

of communication between organizations, groups and individuals involved with compensation problems.

3. That the session permitted a free expression of thought with qualified resource people which allowed for constructive discussion.

4. That it was apparent from the discussion, that the majority of individuals and groups involved with compensation cases have a sincere desire to and interest in seeing that the injured worker is brought through his experience with a minimum of difficulty and with the goal in mind that he will have the same opportunities he had prior to his injury.

Employment of the Handicapped

Charles F. Gross

Discussion of the topic, "Employment of the Handicapped," was opened by Mr. Edmond J. Leonard, Information Director for the President's Committee on Employment of the Handicapped. Mr. Leonard gave a brief summary of the activities of the President's Committee. He pointed out that by executive order President Kennedy had increased the responsibilities of the Committee. The word "physically" having been removed it has become the President's Committee on Employment of the Handicapped giving the committee a responsibility for service to all of the handicapped persons in the labor market including the mentally restored as well as those physically rehabilitated. The President's Committee has added an Employer of the Year Award program as a means of giving public recognition to those employers who do an outstanding job in providing employment of handicapped workers.

Mr. Harlan Noel, representing Indiana AFL-CIO, stressed organized labor's concern and interest in the problems encountered in employment of the handicapped. His organization will seek new legislation in the next session of the State Legislature which would enlarge the Second Injury Fund. AFL-CIO will also seek the appropriation of additional funds for the Vocational Rehabilitation Division which would make possible the provision of rehabilitative services to more handicapped persons.

Mr. Harold Schuman, General Manager of the Indiana Manufacturers Association, gave us some of the ways management views employment of the handicapped. In general, management is sympathetic to the concept of providing equal opportunity based on ability. However, there are many problems including: what is the definition of a handicapped person? how many are there? The practice of hiring all workers at an entry level, usually requiring greater physical fitness than some of the higher rated jobs and the need for flexibility of workers from one type of activity to another at frequent intervals particularly in small plants.

Mr. Howard G. Lytle, Executive Director of Goodwill Industries in Indianapolis, pointed out that perhaps 95% of the physically handicapped have an emotional overlay which creates a greater impediment to employment than the physical limitation. He stressed that adequate evaluation of the handicapped, physically, mentally, and socially, to determine the problems and potentialities was necessary as a basis for appropriate rehabilitation and restoration and eventual job placement.

Mr. Lytle also emphasized the need to give the prospective employer the limitations and problems he should expect in employing as well as the abilities of the handicapped person would bring to his establishment, if employed. He also stressed that the placement of the severely handicapped in employment is an activity requiring a highly trained and dedicated specialist, the search for the right job, and adequate follow-up to see that proper progress is being made.

In the discussion that followed the need for greater education in this field of employment of the handicapped, it was pointed out that pamphlets on how to meet the problems encountered in such employment would be most beneficial.

The group recommends the organization of local committees on employment of the handicapped which would bring together in various communities throughout the State representatives of labor, management, government, and service organizations. This is where the problem must be solved and where the greatest good can be accomplished through organized effort.

Independent Living

Nathan Salon, M.D.

In the last few years, we in Indiana have developed the concept of independent living. This concept stresses that an individual should live in dignity and by his own efforts, in as complete a state of independence throughout his life as is

possible; that every means possible should be made available for such services as are necessary to restore him to self-sufficiency and independent living. It has been recommended that a study be made of the causes leading to the institutionalization of the aged, the physically and mentally handicapped and the chronically ill; and to explore ways by which such individuals may be enabled to maintain their independent living status for the longest possible period of time. This recommendation has the blessing of the Governor and the State Legislative Committee.

The problem of chronic illness, especially as it affects the aged, is rapidly becoming the most serious and the most costly health problem in the United States. Close coordination of all resources is part of the answer to this problem. With the expanding magnitude of the problem, there is a growing disparity in the number of qualified personnel to provide adequate care. A more effective utilization of existing services must be developed as well as the organization of effective programs. There is a tremendous emotional satisfaction in helping someone with a physical handicap to overcome and live with it. It is dramatic, especially when we realize that in most of the cases, there is advantage to most of the disadvantages. We must develop programs to meet the needs of the chronically ill whether a child or an adult; and we must do something to undo the fragmentation that now exists in our own communities.

There are three phases of medicine: prevention, "curative medicine" and surgery, and third, rehabilitation or preparing the patient for independent living.

The body physiologically has enormous reserves—two lungs, two kidneys; four-fifths of the liver can be removed from an animal and the animal still lives. The threshold of function is that area below which the individual cannot function. It may be walking, independence to feed oneself or dress or carry on any of the activities that are meaningful for effective life. Rehabilitation seeks to provide that additional increase of function, whatever it may be.

Medical Rehabilitation is a dynamic concept and active program. Here the skills of the rehabilitation team, consisting of the physician, physical therapist, occupational therapist, speech therapist, nurses, social workers, psychologist or psychiatrist, and other trained personnel are integrated as a single force to assist the patient in reaching the maximum of his physical, emotional, social, and vocational potential.

The practice of rehabilitation for the general practitioner or for any other doctor begins with the belief in the basic philosophy that the doctor's responsibility does not end when the acute illness is over or surgery completed. It ends only when the individual is retrained to live and work with what is left. Rehabilitation must be considered an integral part of medical services.

The first objective of rehabilitation is to eliminate the physical disability where possible; second, to reduce or alleviate the disability to the greatest extent possible; third, to retrain the person with a physical disability to live and to work within the limits of the disability but to the most of his capabilities. Self-sufficiency in job placement or adequacy of self-care is the end objective of rehabilitation. Our care cannot be considered complete until the patient with a physical disability has been trained to "live and work with what he has left." The Physically handicapped person can and must be retrained to walk and travel, to care for his daily needs, to use normal methods of transportation, to use ordinary toilet facilities, to apply and to remove his own prosthetic devices and to communicate orally or in writing. The personal, occupational and social independence of the handicapped person depends on these, which must be made available not only in rehabilitation centers but in every hospital, every nursing home, every county home and for every homebound person. As we stand today, too many people who enter a county home, a nursing home, or old people's home are allowed to deteriorate. It is a one-way street leading to death.

One of the services that will implement our philosophy of independent living is the home care program. This is a method of bringing hospital-type care into the patient's home with the full complement of medical, nursing, and social services. It is an effective and economical method of treating patients with long-term illness. It has positive values for the patient and his family, as well as for the hospital, the physician, and the community as a whole.

One more concept that I feel should be mentioned. We need to learn more about the psychodynamics of older people. Advanced age is not a bar to recovery or from mental illness. The majority of patients 65 and over with mental illness can be restored to the community and need not spend their remaining days in a State

institution. Even patients who have spent a long time in State Hospitals need not automatically be regarded as incurable. More accurate diagnosis of the mental illnesses of the aged may lead to more active and appropriate treatment. Old age is not contra-indicated to usual treatment which includes psychotherapy, chemotherapy, and electro-convulsive treatment. Adequate and intensive care can restore a number of these patients to the community and independent living.

Before presenting this subject for general discussion and for possible development of some recommendations, I should like to mention several important steps that we must think about in this frame of references:

1. *Comprehensive Medical Care.* We must employ a wide variety of skills and techniques in assessing, determining and carrying out treatment and rehabilitation plans for the individual patient. Modern medicine demands a wide variety of special skills.

2. *Sound Medical Diagnosis.* This is necessary for the patient to get the full benefit of the treatment.

3. *Consider the Individual in the Real World.* His life as he actually lives it is called "Social Environment." Relate medical treatment plans to the environment, to the family, the housing, the income, the job.

4. *Medical and Other Services Must be Well Coordinated.* They are not efficient if the patient is the coordinator. Example: the child being treated by three different clinics for three different conditions—heart, orthopedics, ear, nose and throat.

5. *Diagnostic Services and Special Rehabilitation Services* must be made more widely available in the community and the practicing physician must be knowledgeable and in touch with these resources.

6. *Case Finding.* Take advantage of accumulative resources. Example: We can locate heart abnormalities from the chest x-ray for T. B. We must look for methods for diabetic case-finding and also simple tests for cervical cancer.

7. *High Quality of Care Necessary* along with meeting the quantitative need for services. We must avoid dilution of quality of care.

Resolutions

I. Be it resolved that all mentally and physically disabled persons be provided with the opportunity and means to be rehabilitated to the fullest extent within their capabilities to maintain a status of independent living.

II. Be it resolved that in order to fulfill resolution I to provide services for independent living, we need to encourage and promote more people to enter and complete training in the various rehabilitation disciplines.

III. Be it resolved that in the licensure program for school administrators, the stipulation be included that the applicant have had some academic work in the counseling and guidance and the health fields.

IV. Be it resolved that the Hospitals, Medical Societies, and State Board of Health be commended for their efforts in establishing home care programs.

V. Be it resolved that communities and agencies be encouraged to initiate and develop those home services necessary to accomplish independent living.

VI. Be it resolved that medical schools be encouraged to give more emphasis to chronic diseases, preventive techniques, geriatrics and physical medicine; that practicing physicians become more knowledgeable in these fields.

VII. Be it resolved that recognizing these resolutions only partially point up our needs, we recommend the Commission for the Handicapped develop specific plans for the training and involvement of additional personnel to work with the handicapped and that the Commission report on its recommendations at the next annual meeting; The Commission for the Handicapped appoint a special committee to develop such recommendations.

Education of the Handicapped

Tony C. Milazzo

Approximately fifty persons attended this section meeting including teachers, therapists, parents, administrators, superintendents, nurses, physicians. Most of the various areas of special education from both state and local levels were represented.

The section meeting began with an overview of history and legislative developments of education for the handicapped in the public schools of Indiana.

Each area of special education was then discussed including visually handicapped, physically handicapped, deaf and hard of hearing, emotion-

ally disturbed, speech and hearing handicapped, mentally retarded, special administration, and school psychological services from the standpoint of: (1) accomplishments since last conference, (2) discussion of needs, (3) recommendations for further action. A report was presented of the new training program for teachers of the deaf at Ball State supported by a recent federal grant.

A report of a study mandated by the 1961 Indiana General Assembly concerning the method of state reimbursement for special education and the philosophy behind was presented.

Accomplishments Since Last Conference

The following points of accomplishment were discussed:

1. Growth of special education program in the public schools (i.e., 1500 more pupils enrolled in 1961-62 over 1960-61; total enrolled 1961-62 was 30,551.
2. Improvement of quality of programs due to provisions in rules and regulations and additional consultative services at the state level and increase in administrative and supervisory personnel at the local level.
3. Revision of certification patterns in all areas and the development of new certification patterns in areas not formerly covered by certification. There is now certification in each area of exceptionality and a director of special education certificate.
4. Extension of reimbursable services to school psychological services and local directors of special education as a result of 1961 legislation.
5. Establishment of precedent for the establishment of programs for experimental purposes (i.e., special approval by Commission on General Education to allow for experimental programs for the emotionally disturbed, brain injured, and summer speech and hearing therapy).
6. Survey of practices in hearing screening and consideration of legislation regarding hearing screening by the Hearing Commission and the Division of Special Education.
7. Additional staff in the Division of Special Education, including a Supervisor, Programs for the Physically Handicapped and a Supervisor, School Psychological Services.
8. New training program for teachers of the deaf at Ball State made possible by federal legislation.
9. Program established for training teachers of the emotionally disturbed at Indiana State.
10. Plans for training programs for directors and supervisors of special education at several of the state colleges and universities.
11. Emphasis upon coordination of agencies, services, disciplines.
12. Study of the reimbursement method and the philosophy behind it and the development of recommendations for legislation as a result.
13. Two yearly grants for the advanced training of local and state directors and supervisors of special education created under provisions of P. L. 85-926.

Major Points of Discussion

1. Probably the greatest need in the area of education of the handicapped is that of recruitment of personnel and the conservation of such personnel after they are employed. Steps should be taken by all agencies, services, discipline in much greater activity in this area.
2. There continues to be a need for in-service training programs of various types:
   a. summer short-term workshops;
   b. more localized or community and regional workshops and conferences;
   c. more jointly operated conferences and workshops for low incidence groups (i.e., blind, deaf).
3. Much more attention needs to be given to certain types of problems heretofore receiving relatively little attention; such as: brain-injured, multiple handicapped, aphasic, emotionally disturbed, hard-of-hearing, visually handicapped.
4. There should be an extension of programs for mentally retarded to the trainable and the older educable mentally retarded.
5. There is a need for extending the college and university training programs for all special education areas including teachers, therapists, administrators and supervisors, school psychologists, etc.
6. There should be continued emphasis upon community education for both lay and professional persons both from the standpoint of community acceptance and understanding and increased communications among agencies, services and disciplines.

Proposed Legislation

It was reported that the following amendments to existing legislation concerning the education of handicapped children have been proposed and a bill prepared for introduction into the 1963 Indiana General Assembly.

1. Burns 28-3523 should be amended to eliminate the excess cost method of state reimbursement and replace this method with a state reimbursement method based on percentages of specific approved expenditures.
   a. reimbursement at the rate of 50% of the special class teachers salary and 70% of the speech and hearing therapists salary, including the salary for the time spent by these therapists in hearing screening, would allow for the varying costs of special education programs, provide more equitable reimbursement, and, therefore, encourage the establishment and expansion of special education programs.
   b. State reimbursement at the rate of 50% of the cost of special administration and psychological services, the rate presently utilized, provides sufficient encouragement to local schools.
   c. State reimbursement at the rate of 80% of the cost of special transportation, home teacher, and school-home telephone programs, essentially the rate presently utilized, provides adequate State support.
2. Burns 28-3529 should be amended to provide that if sufficient funds are not available from the common school interest fund and the excise fund to meet claims for reimbursement that funds be available from the general fund to meet such claims.
   a. Best estimates of state funds presently available to meet claim for reimbursement of special education programs in the local schools, indicate that such funds may be insufficient to meet claims for the next biennium.
   b. The distribution for 1961-62 was held up for about one month in order to make funds available to avoid prorating for this year. It is possible that the 1962-63 distribution will need to be prorated.
3. Burns 28-3521 should be amended to include gifted children or those having superior intellectual capacity in the definition of children for whom local school corporations may establish special education programs for reimbursement purposes.
   a. It is expected that there are approximately 21,000 children in Indiana who are gifted and in need of a special education program. A recent survey by the Division of Special Education indicates that there are less than ten school corporations operating such programs. These programs include less than 1,000 children or about 5% of those in need.
4. Burns 28-3530 should be amended to increase the funds for the operation of the Division of Special Education to provide for increased supervisory and consultative personnel.
   a. The following staff for the Division of Special Education is proposed:
      1 Director
      1 Assistant Director
      1 Supervisor, Programs for Mentally Retarded
        1 Consultant, Classes for Educable Mentally Retarded
        1 Consultant, Classes for Trainable Mentally Retarded
      1 Supervisor, School Psychological Services
      1 Supervisor, Speech and Hearing Services
        1 Consultant, Speech and Hearing Therapy
        1 Consultant, Deaf and Hard of Hearing
      1 Supervisor, Programs for Physically Handicapped
      1 Supervisor, Programs for Visually Handicapped
      1 Supervisor of the Gifted
      1 Research Associate
      4 Instructor-Supervisors (* half-time)
      6 Secretaries

* To spend half-time in work for the Division of Special Education and half-time on the staff of a college or university having a training program in special education.

Community Coordination and Planning for the Handicapped

Robert Yoho, H.S.D.

One of the first points made by the discussants in this group was the need for making the public aware of the problems of the handicapped. The removal of architectural barriers was one activity that was mentioned as having possibilities of developing general community interest in the handicapped individual. Once a community had taken part in a program designed to remove such barriers, these individuals found real satisfaction in the accomplishment of a tangible result. With a sense of accomplishment in this area, individuals are willing to continue in programs which offer less tangible results in the field of rehabilitation.

Various methods of achieving community coordination and planning were mentioned, such as the establishment of a separate agency with the delegated responsibility of coordinating rehabilitation efforts. In most communities, however, there are already in existence, organizations which might readily broaden their interpretation of objectives to include the mechanics of coordinating programs for the handicapped.

Throughout the discussion period, a dominant thread dealt with the need for public education concerning the problems of the handicapped and most of the time allotted was taken up by a discussion of the various media used to interpret these problems. In addition to the mass communications media — press, radio, television — community outlets such as parent-teacher groups, chambers of commerce, and others, were suggested as possible direct channels to reach specific groups in the community.

AWARDS

The Governor's Rehabilitation Awards were presented at the Conference Banquet by the Commission Chairman, Neal E. Baxter, M.D.

As you are aware, the Commission for the Handicapped has been affiliated with the President's Committee on Employment of the Handicapped since August 31, 1961.

The Governor's Rehabilitation Awards program was developed as a result of this relationship. The purpose of this awards program is to honor deserving persons and organizations in Indiana's effort to increase employment opportunities for the handicapped. The program is also developed to correlate with the pattern of the President's Committee's awards program.

It should be kept in mind that a primary consideration in these awards is the *emphasis on providing an opportunity for employment* to handicapped individuals in Indiana.

One other remark I might make is that it is *not* the Commission's feeling that all awards *must* be made each year. The presenting of an award will be determined by the nominations received and their appropriateness in relation to the established criteria for each award.

Before making the awards, I would like to recognize the work of the Awards Committee who, under the direction of the Chairman, Dr. Frank M. Hall, have had the responsibility for developing this program.

Employer's Merit Award

Employer's Merit Award is given to an employer, a business agency, or an establishment that has an exceptional record for employing the handicapped. The purpose of this award is to recognize publicly those employers who, through their personnel department, utilize the handicapped throughout their total labor force.

This year's recipient is The Bendix Corporation, South Bend, nominated by Mr. M. O. Jeglum, Executive Director of the Indiana Society for Crippled Children, Indianapolis. The employment policies of the Bendix Corporation have resulted in the employment of 6,510 persons who are classified as handicapped, which represents 14.8% of the total labor force. The handicapped workmen are *distributed throughout* the Bendix organization and include all major types of handicapping conditions and types.

It is my pleasure to present this award to the Bendix Corporation of South Bend. This award will be accepted by Mr. L. A. Tiedge.

Public Personnel Award

The Public Personnel Award is a special distinguished service award conferred on an individual employed in a public agency located in the State of Indiana. (Federal, state, local, or municipal, or a public school system.)

The purpose of the award is to honor a personnel official or other worker who is making exceptional contributions to the employment of the handicapped in the public agency where he is employed. It is hoped that this award will encourage employment of qualified handicapped persons in the public service consistent with competitive qualification policies, and that an increase in opportunities for the handicapped will result.

Recipient of this year's award is Mr. Jerome F. Henry, Director of Social Service, Fort Wayne State School, Fort Wayne. Home address is 4761 St. Joe Road, Fort Wayne. Mr. Henry was nominated by Bernard Dolnick, Superintendent of the Fort Wayne State School. He has been an employee of the Fort Wayne State School since November 9, 1956; has a Master's Degree in Social Work; has always been extremely interested in helping the handicapped. He is particularly interested in the plight of the blind and has trained several persons to work under his guidance. Mr. Henry is presently promoting and developing a blind-typist pool to serve the various social agencies under the Fort Wayne United Chest Council and United Fund. Mr. Henry believes that using such typists to transcribe taped confidential case histories will be efficient and satisfying to the agencies as well as presenting an opportunity for employment to these handicapped persons. In his work, Mr. Henry has given major emphasis to establishing a program that will find permanent employment for residents leaving the Fort Wayne State School for the Retarded. His concerted efforts in this area have resulted in a higher percentage of the Fort Wayne State School residents becoming successfully self-sustaining in the community.

It is my pleasure to present this award to Mr. Jerome F. Henry.

Distinguished Service Award

The Distinguished Service Award may be awarded to any Indiana organization, agency, or individual making an outstanding contribution

in advancing the employment of handicapped Americans.

This award is given to extend public recognition for meritorious service in promoting better public understanding of the employment capabilities of the handicapped. It is hoped that through this recognition others will become interested, public understanding enhanced, barriers removed, and opportunities expanded for suitable useful employment of the handicapped.

Recipient of this year's award is Miss Norma Baumann, Director of Medical Records Department, Methodist Hospital, Indianapolis. Miss Baumann was nominated by Byran A. Rogers, Associate Director of Methodist Hospital. She has served Methodist Hospital since 1944 as Director of the Medical Records Department. In this position she is responsible for the activities of 40 clerical and professional persons. Miss Baumann has been especially interested in, and has done outstanding work, with blind personnel. In 1951 she initiated a program for training blind persons in highly technical procedures which has given them economic independence and job satisfaction through opening doors to opportunities which would otherwise have been closed. Due to her personal leadership and initiative in training blind persons to turn their disabilities into abilities, and her competence in her profession nationally, this program of utilizing blind employees has been copied by other such departments throughout the nation.

It is my pleasure to present this award to Miss Norma Baumann.

The Governor's Trophy

The Governor's Trophy may be awarded each year as a special honor to a handicapped Hoosier who has surmounted his or her own handicap to become a useful citizen, and who has helped to encourage and inspire or facilitate the employment of other handicapped persons.

This year's recipient is Mr. Jack High, Lafayette, Ind.

Mr. High was nominated by the following persons: Mrs. Carl E. Johnson, President of Tippecanoe County Unit, American Cancer Society; George I. Shaffer, Ph.D., Assistant Director, Speech and Hearing Clinic, Purdue University; Don C. Fields, M.D., The Arnett Clinic, Lafayette, Indiana.

Mr. High is a laryngectomee having undergone surgery for cancer in July of 1960. He began practicing the use of esophogeal speech even before the surgery and within a month of the operation was able to go back to his job as salesman for the Curtis-French Surgical Supply Co. Prior to his operation, Mr. High had participated in many musical groups both singing and directing and he still directs the Lafayette Civic Chorus. Mr. High and his family were selected as the Indiana Cancer Crusade Family for 1962 and in this capacity has spoken to very many groups over the state. He gives much time to the work of the Cancer Society and other organizations, such as the Tippecanoe Lost Chord Club, and the Indiana Association of Laryngectomees. Mr. High does outstanding work in counseling individuals facing laryngectomy, helping them to prepare for it emotionally, and assisting them in learning the techniques of esophogeal speech following surgery. Mr. High has worked with many persons over the State helping them to return to their old positions, or assisting them to find new employment. Each such case is considered a personal challenge.

It is my pleasure to present the Governor's Trophy to Mr. Jack High.

SPECIAL INTEREST SESSIONS

Eighteen voluntary health agencies in Indiana were invited to use a two-hour block of time on the second morning of the Governor's Second Conference on the Handicapped. There were no stipulations as to how this time was to be used and no report to the general Conference was requested. The following organizations accepted the invitation of the Commission for the Handicapped and presented programs in their area of special interest:

American Cancer Society, Indiana Division.
The National Foundation — March of Dimes.
Indiana Society for Crippled Children and Adults.
Indiana Epilepsy Society, Inc.
Indiana Association for Retarded Children.
Indiana Association for the Deaf.
Indiana Chapter Myasthenia Gravis Foundation.
Indiana Society for the Prevention of Blindness.

A survey of these agencies shows that they were pleased with the response to their meetings at the Conference and that they hope to participate in future conferences.

CONFERENCE STATISTICS

Total number of persons registered for conference		292
Meals served:	Lunch, October 10	139
	Coffee, October 10	110
	Banquet, October 10	170
	Lunch, October 11	123
Attendance at Discussions Sessions, October 10		
	Independent Living	29
	Workmen's Compensation	17
	Employment of the Handicapped	31
	Architectural Barriers	20
	Community Coordination and Planning	75
	Education of the Handicapped	50
	Total	222

The Conference registration cards requested that each registrant indicate the organization he was representing and his major personal interest. Following is a compilation of these responses. In no case should the totals given be construed as the total representation of these agencies or of the various fields of interest listed.

FEDERAL AGENCIES	
Veterans Administration	1
STATE AGENCIES	
State Board of Health	17
Division of Special Education	3
Division of Vocational Rehabilitation	26
Agency for the Blind	7
Public Welfare (state and local)	10
State Commission on Aging	2
Commission for the Handicapped	10
State Board of Education	1
Employment Security Division	1
COLLEGES AND UNIVERSITIES	
Indiana University	1
Butler University	1
Indiana University Medical Center	2
Indiana State College	1
Ball State Teachers College	1
HOSPITALS	
Medical	13
Mental	4
RESIDENTIAL SCHOOLS	
Indiana School for the Deaf	9
Indiana School for the Blind	1
Fort Wayne State School	3
Muscatatuck State School	2
PROFESSIONAL ASSOCIATIONS	
Indiana State Dental Association	1
Indiana State Medical Association	1
Indiana Physical Therapy Association	1
Indiana Public Health Nursing Association	1
PRIVATE FACILITIES	
Goodwill Industries	13
Sheltered Workshops for the Retarded	3
Rehabilitation Centers	7
Private Schools	7
VOLUNTARY ORGANIZATIONS	
Indiana Society for Crippled Children	9
Indiana Heart Association	2
Ind. Society for Prevention of Blindness	1
Myasthenia Gravis	6
Association for the Blind	3
Epilepsy Associations	2
Ind. Association for Retarded Children	5
National Foundation	7

Associations for the Deaf	1
Multiple Sclerosis Society	1
Mental Health Associations	1
Cancer Society	1

OTHER

Organized Labor	3
Students	34
Local Health Departments	2
Community Councils	2
Public Schools	8
Out-of-state Visitors	4
Persons not indicating an organization	33
Miscellaneous	17

Major Interests of Persons Attending the Conference

General Rehabilitation	18
Vocational Rehabilitation	14
Rehabilitation Counseling	14
Speech and Hearing	16
Optometry	22
Recreation	2
Public Health	5
Nursing	10
Social Work	8
Teaching	7
Physical Therapy	6
Occupational Therapy	2
Special Education	14
Medicine	6
Psychology	2
Partially Sighted and Blind	10
Mental Retardation	9
Aging	2
Deaf	2
Mental Illness	1
Interest not indicated	122

ATTENDANCE LIST

John Adams
4811 Magoun Avenue
East Chicago, Indiana

James R. Alley
6541 Parker Lane
Indianapolis

Merrill J. Allen*
1009 South Manor Road
Bloomington

Jean L. Anderson
4732 Boulevard Place
Indianapolis

Theodora Allen*
Apt. 322, University Apts.
Bloomington

Richard J. Anderson
4630 Rookwood
Indianapolis

Patricia Arnold*
818 East Third Street
Bloomington

John G. Ashman*
Bloomington

Wallace Baker
202 North Mount
Indianapolis

Thomas L. Baldwin
7996 E. 10th Street
Indianapolis

Wm. R. Baldwin*
708 S. Woodlawn
Bloomington

Norma Baumann
1922 North Capitol Avenue
Indianapolis

Neal E. Baxter, M.D.
306 East 5th Street
Bloomington

* Student

Norman J. Beatty
832 Indiana Building
Indianapolis

J. E. Berkshire
2701 Mishawaka Avenue
South Bend

Jack G. Berry
Indianapolis

Jim Best
3744 East 55th Street
Indianapolis

Mrs. W. H. Biddlecombe
520 E. 54th Street
Indianapolis

Lynn Black*
1410 North Jordan
Bloomington

Raphael Blessinger
715 Clay Street
Jasper

Patricia Bowser
536 W. 30th Street
Indianapolis

David Bridgford*
540 Basca Drive
Martinsville

Leslie Brinegar
Room 225 State House
Indianapolis

Mrs. Carol Browand
5430 Maumee Avenue
Fort Wayne

Thomas C. Burkhart*
Bloomington

Mrs. Nell B. Buse
1111 Wayne Terrace
Lafayette

Kenneth W. Bush
4433 Priscilla Avenue
Indianapolis

Marcia Butcher
1100 West Michigan Street
Indianapolis

Dolores Campbell
R. R. #2
Elwood

Mary Sue Carroll
902 North 7th Street
Vincennes

Lorene Catte
Goodwill Industries
Terre Haute

Nancy C. Chambers
R. R. 4
Spencer

Kenneth I. Chapman
615 North Alabama Street
Indianapolis

Jack W. Clark
1219 E. Dubail Avenue
South Bend

Mary K. Clark
Spencer

Elizabeth Cleghorn
Richmond Combined Enterp., Inc.
Richmond

Jane Coffee
903 Edgewater
Fort Wayne

Earl T. Cogan
6225 Chaddsford
Fort Wayne

Mrs. Don E. (Bette) Collins
25 Central Way
Anderson

Dick Collins
801 East State Street
Fort Wayne

Wm. J. Collins
414 S. E. First
Evansville

Gale E. Coons
721 Hume Mansur Building
Indianapolis

Roger W. Coulson
Butler University
Indianapolis

Elaine Cowen
4314 Bertrand Road
Indianapolis

Estella B. Crawford
5613 East Washington Street
Indianapolis

Diane Coenman*
1407 East 10th Street
Bloomington

Isabel Craig*
R. R. #1
Bloomington

Charles F. Crews
Bloomington

Bernice Crumbaugh
732 West 7th Street
Anderson

Donald J. Daugherty
1100 Waggoner Avenue
Evansville

Dr. George Davis
1015 State Office Building
Indianapolis

Richard J. Davis*
1604 Redbud Hill
Bloomington

Dr. M. B. Deems
6830 Arcadian Highway
Evansville

* Student

Mrs. M. B. Deems
6830 Arcadian Highway
Evansville

Lois Thoms Dickason*
415 N. Dunn—Apt. #4
Bloomington

Grace Dombrowski
8733 Pine Street
Gary

Theodore Dombrowski
4822 West 5th Street
Gary

Keith O. Dunlap*
701 N. Lincoln
Bloomington

Gayle S. Eads
401 State House
Indianapolis

Joseph W. Elbert, D.O.
711 Main Street
Petersburg

Mrs. Opal Elbert
R. R. #2
Petersburg

Kathryn Emig
Goodwill Industries
Evansville

Roy N. Fenn
Tell City Chair Company
Tell City

Phoebe Fickest
615 North Alabama, #218
Indianapolis

Mrs. Margaret Garner
200 East Lutz
West Lafayette

Daniel A. Gawrouski
6412 Arizona Avenue
Hammond

Mary Gaynor
100 Van Nuys Road
New Castle

Joseph L. Gehris
4243 N. Edmondson Avenue
Indianapolis

George E. Gill
5908 University Avenue
Indianapolis

Gunella R. Gillard
101 Forest Avenue
Muncie

Dorothy Gillman
702 Williams Street
Elkhart

A. B. Ginn
930 Division
Evansville

Dr. S. T. Ginsberg
1315 West 10th Street
Indianapolis

Mrs. Oliver Good
137 Shady Lane
Wabash

Edward T. Gorman
4811 Magoun Avenue
East Chicago

Mrs. John W. Gowdy, Sr.
1946 N. Moreland Avenue
Indianapolis

Theodore Grob
122 North 5th Street
Terre Haute

Charles F. Gross
Indiana Employment Sec. Div.
Indianapolis

Ruth Grummon
6255 Sunnyside Road
Indianapolis

A. A. Hajna
3202 North New Jersey Street
Indianapolis

Doris Hanks
309 West Stadium
West Lafayette

Thelma Hale
Box 13
Sulphur Springs

Frank M. Hall, M.D.
100 North Senate Avenue
Indianapolis

Floyd W. Hammond
1301 N. Audubon Road
Indianapolis

William J. Hamrick
5 Marigold
Terre Haute

Dale Harmon
2428 Brookside Parkway
Indianapolis

C. D. Hawblitzel
2701 Mishawaka Avenue
South Bend

Eva Herkamp
3258 Broadway
Indianapolis

Elmer Heller
Lawrenceburg

John E. Helme
P. O. Box 376
Seymour

Charles E. Henley
705 East Pearl Street
Greenwood

Mrs. Charles (Louise) Henley
705 East Pearl Street
Greenwood

Jerome F. Henry
4761 St. Joe Road
Fort Wayne

John A. Hetherington, M.D.
7744 Graham Road
Indianapolis

H. Allan Heuss
301 East Streeter
Muncie

* Student

Mrs. Clarence Higi
210 Alden Road
Muncie

H. W. Hofstetter
Indiana Univ. Div. of Optometry
Bloomington

Paul H. Hoge
Route #2, Box 221
Danville

Patricia Ann Holland
2 West 52nd Street
Indianapolis

Mrs. Virginia Holmes
3497 Birchwood Avenue
Indianapolis

Dr. Richard A. Hoops
810 Carson Street
Muncie

Harriett Huddle
410 South Jordan
Bloomington

Harold D. Huffine
219 W. North Street
Tipton, Indiana

Robert P. Huffman
2204 Beck
Lafayette

Mrs. David Hunt
451 North Grand
Lafayette

D. A. Hutchinson
7725 North College Avenue
Indianapolis

Gary Lee Jeffries
Pershing

M. O. Jeglum
10699 Highland Drive
Indianapolis

Donald H. Jolly, M.D.
Muscatatuck State School
Butlerville

Robert W. Jones
Morristown

Dr. John Kalsbeck
Special Treatment Center
I. U. Medical Center
Indianapolis

Nicholas Kayafas
109 Nottingham Drive
Portage

Mrs. Richard Kearschner
Goodwill Industries
Terre Haute

Freeman D. Ketron
401 State House
Indianapolis

Wilburn Kifer
Evansville College
Evansville

Donald Koors
Indiana Agency for the Blind
Indianapolis

Mrs. Donald Koors
6124 Broadway
Indianapolis

Don C. Kortpeter
318 East Second Street
Marion

Shirley Krug*
1410 Jordan
Bloomington

Mrs. Richard Kratz
Evansville

Alfred J. Lamb
1200 East 42nd Street
Indianapolis

James O. Larsen
5525 Indianola Avenue
Indianapolis

Matilda Lebline
307 Harned Avenue
Washington

John J. Lee, Ph.D.
Wayne State University
Detroit

Lorine Lehner
5109 Park Avenue
Indianapolis

Noble C. Lehner
5109 N. Park Avenue
Indianapolis

Herman Litschgi
Evansville College
Evansville

Mrs. Mary Litty
11½ Main Street
Evansville

Edmond J. Leonard
Falls Church
Virginia

Mrs. Floyd B. (Dorothy) Lux
1812 Kossuth Street
Lafayette

William M. Lyle*
310 Campus View House
Bloomington

Howard G. Lytle
1635 West Michigan Street
Indianapolis

Mrs. Howard G. Lytle
415 West Westfield Blvd.
Indianapolis

Dr. O. B. McAtee
Madison State Hospital
Madison

Leone McCain
Dept. of Public Welfare
Rushville

Boyd McCandless
School of Education, I.U.
Bloomington

* Student

Mrs. Boyd McCandless
1921 E. Third Street
Bloomington

Charles A. MacCausland
20531 Darden Road
South Bend

William J. McClure
1200 E. 42nd Street
Indianapolis

Marion MacDonald
227 S. Michigan Street
Elkhart

Ralph E. McDonald, D.D.S.
1121 West Michigan Street
Indianapolis

Sarah K. McGregor
1000 Corregidor
Evansville

J. C. McLain
18 David Drive
North Vernon

H. B. McGuire
Terre Haute

Mrs. Mary B. Mann
609 South Jordan
Bloomington

M. G. Manwaring
11420 Trails End
Noblesville

Catherine E. Martin
Route 1, Box 19
Pekin

Daniel C. Martin
Wabash School
Lafayette

Molly Martin*
Goshen

Carl D. Martz, M.D.
Hume Mansur Building
Indianapolis

Malcolm Mason
1330 West Michigan Street
Indianapolis

Mrs. A. B. Masters
2507 Elizabeth
Lafayette

Nancy Meyer*
Everman Apts., #245
Lafayette

Tony C. Milazzo
225 State House
Indianapolis

Mrs. Kathleen Milburn
133 Griffin Road
Indianapolis

Felix Millan, M.D.
960 Locke Street
Indianapolis

Mrs. Felix Millan
2829 Kessler Blvd., N. D.
Indianapolis

Delma Miller*
Campus View Apts. E-415
Bloomington

Erskine Miller
3841 Priscilla
Indianapolis

Maurine Miller
9515 Copley Drive
Indianapolis

Spiro B. Mitsos, Ph.D.
3701 Bellemeade Avenue
Evansville

Sylvia M. Morby
26 E. 14th Street
Indianapolis

Ben Morgan
150 North Meridian Street
Indianapolis

H. J. Noel
910 North Delaware Street
Indianapolis

John A. Norris
910 North Delaware Street
Indianapolis

P. C. Neidlinger
10321 North New Jersey Street
Indianapolis

Francis Nasca
I. U. Speech and Hearing Clinic
Bloomington

Mrs. George Nagel
578 North Wabash Street
Wabash

Robert Emery Neff
37 E. 52nd Street
Indianapolis

Mrs. Robert E. Neff
37 E. 52nd Street
Indianapolis

Jack Oathout
Cortland

Mike Obremsky*
Bloomington

Carol Ann Oehlhoffen
960 Locke Street
Indianapolis

Mary C. Ohnmacht
2307 Butler
Lafayette

Diana Olson*
R. R. 5, Box 333
Antioch, Illinois

Mrs. E. F. Ortmeyer
219 South Alvord
Evansville

Bill J. Palmer
507 S. Carver
Garrett

Randi Palmer*
1000 North Jordan
Bloomington

* Student

Elaine Patren
P. O. 65
Wabash

Roy E. Patton
Crossroads Rehabilitation Center
Indianapolis

Don G. Pettingill
301 State House
Indianapolis

Ralph N. Phelps
5841 North College Avenue
Indianapolis

Nina D. Pick
210 E. 51st Street
Indianapolis

Rosamond M. Pitman
1418 "G" Street
Bedford

Reverend Daniel H. Pokorny
3421 North Park Avenue
Indianapolis

Mrs. C. M. Poor
5107 Graceland Avenue
Indianapolis

Rutherford B. Porter, Ph.D.
Indiana State College
Terre Haute

John Paul Price
401 State House
Indianapolis

M. E. Price
6142 Compton
Indianapolis

Mrs. Fred Pullen
R. R. 1
La Gro

H. S. Rabinowitz
3701 Bellemeade
Evansville

Letty Randall
206 West Maryland Street
Evansville

Thelma Ransdell
R. R. 12
Lafayette

Richard Roan
4024 Oakland Drive
Fort Wayne

Mrs. George F. Reeves
2802 Lincoln Street
Anderson

Milt Reisman*
901 Atwater
Bloomington

Richard M. Reimbold
231 East Market Street
Jeffersonville

Mary Jane Rhodes
4421 College Avenue
Indianapolis

Mary Ann Ricca
130-9 Marshall Drive
Lafayette

Robert Rice
966 North Meridian St., Rm. 205
Indianapolis

Mrs. Eva Richbourg
3904 Arborcrest Drive
Indianapolis

Al Rieger
Evansville Assoc. for the Blind
Evansville

Mrs. Cecil Rigney
R. R. #1
La Fontaine

Jack L. Rivers
2437 Taylor Street
Madison

Lennes S. Rodenbeck
Dept. of Public Welfare
Spencer

Edwina Roberts
Public Health Nursing Assn.
Henderson, Kentucky

Tom Robbins*
Bloomington

Alex T. Ross, M.D.
Department of Neurology
I. U. Medical Center
Indianapolis

Mrs. May Roubadeaux
303 E. 6th Street
Bloomington

Mrs. William D. Ruckelshaus
4950 Graceland Avenue
Indianapolis

Guy F. Russell
624 W. 40th Street
Indianapolis

Mrs. Niel Rusterholz
(Mary Louise)
30 Tidewater Drive
Hagerstown

Susan Sandberg*
309 Curry House
Bloomington

Mrs. Clotilde P. Sanguinet
1100 West Michigan
Indianapolis

N. L. Salon, M.D.
603 West Wayne Street
Fort Wayne

James R. Salyers
Suite 305, 310 W. Liberty St.
Louisville, Kentucky

Lucretia Ann Saunders
1330 West Michigan Street
Indianapolis

Mrs. Vernand Scharrer
3860 Arborcrest
Indianapolis

H. Joan Schaub
7911 Bonita Court
Indianapolis

* Student

John C. Schertzinger*
Bloomington

Mrs. Helen L. Scheibner
1330 West Michigan Street
Indianapolis

Forrest W. Schepper
Vocational Rehabilitation Division
Anderson

Stuart Schlageter
148 E. Spring Street
New Albany

Rex S. Schlegel*
708 S. Cory Lane
Bloomington

Carl H. Schmidt*
Bloomington

Paul Schmidt
8090 Payne Road
Indianapolis

Ingeborg Schmidt
I. U. Division of Optometry
Bloomington

Harold L. Schuman
4149 S. Post Road
Wanamaker

Davis A. Scott
512 N. Indiana
Bloomington

Geoffrey Segar
111 Monument Circle
Indianapolis

Robert Seitz, Jr.*
3671 Hays
Bloomington

Carol Senese
5125 W. 10th Street
Indianapolis

David S. Shelton
3701 Bellemeade
Evansville

Dolores Shinkel
2230 Chase Street
Anderson

Mrs. Edward Shipley
3601 Marrison Place
Indianapolis

Richard O. Shock
1341 Fay Drive
Fort Wayne

O. W. Sicks, M.D.
607 E. 82nd Street
Indianapolis

E. M. Sirlin, M.D.
109 S. Church
Mishawaka

Betty L. Smith
966 North Meridian St., #205
Indianapolis

Howard H. Smith
1330 W. Michigan Street
Indianapolis

Jen M. Smith
P. O. Box 622
Indianapolis

Lois Ann Smith
4514 West 28th Street
Indianapolis

Lowell B. Smith
313 Scheller
Sellersburg

Mrs. Katherine Snow
I. U. Speech & Hearing Clinic
Bloomington

Ronald G. Snyder*
1200 N. Indiana #44
Bloomington

Francis L. Sonday, Ph.D.
Audiology and Speech Clinic
I. U. Medical Center
Indianapolis

Louis W. Spolyar, M.D.
1330 West Michigan Street
Indianapolis

H. E. Stamm
Methodist Hospital
Gary

Judith Stockmann
R. R. #1
Washington

William S. Stohlman
227 East Washington St.
Fort Wayne

Jerry L. Stroud
3520 N. Grant
Indianapolis

James D. Studebaker*
Walnut Grove #28
Bloomington

Monte Stump*
924 E. Atwater
Bloomington

Bert Talbott
966 North Meridian St., #205
Indianapolis

Mrs. Ailene Tarasick*
426 Ramion
Michigan City

Harvey I. Therrier
R. R. 1, Box 234
Centerville

G. Linden Thorn
4183 Broadway
Gary

Harry E. Tiffee*
705 N. Lincoln
Bloomington

Stanley M. Tillman*
Bloomington

Carolyn C. Tucker
6160 Afton Crest
Indianapolis

Kenneth L. Turner*
Banta Apartments F-124
Bloomington

Steve Van Cleve*
Bloomington

James H. Veale
331 South Dunn
Bloomington

* Student

Eugene F. Vollmer
4327 Broadway
Indianapolis

Floyd T. Walker
1302 Nichol Avenue
Anderson

Harrold W. Wallace
921 Marsh Street
Muncie

Maude R. Ward
P. O. Box 15
Pendleton

Mrs. Lorena Walters
Freelandville

Gilbert M. Warner
Richmond

Margaret Warner
709 Clay Street
Fort Wayne

Robert W. Watkins
801 East State Blvd.
Fort Wayne

Mrs. Fern Weir
5716 Ralston Drive
Indianapolis

Gwyneth Weese*
Virginia Avenue
Salem

Maude J. Welsh
318 Mound Street
Tipton

Owen C. Wemhoff
7428 Capri
Fort Wayne

Ralph B. Werking, Jr.
6055 College Avenue
Indianapolis

James L. Wessar*
Bloomington

Lois Ann Whetsel
2626 Bowser
Fort Wayne

Charley Whisman
4316 Carrollton Avenue
Indianapolis

Charles R. White
622 S. Center
Terre Haute

Philip T. White, M.D.
Neurology Department
I. U. Medical Center
Indianapolis

E. B. Whitten
National Rehabilitation Assn.
1025 Vermont Avenue
Washington, D. C.

Florence M. Winslow
Indiana Agency for the Blind
Kokomo, Indiana

James A. Wolf
3916 Washington Blvd.
Indianapolis

Harvey S. Woll*
7207 Jarboe Street
Kansas City, Mo.

Mrs. J. R. Woods, Jr.
11 N. State
Greenfield

Jerry A. Woollen
1330 West Michigan Street
Indianapolis

Mrs. Andree Wooten
5564 Meadowood Drive
Speedway

Robert O. Yoho, H.S.D.
1330 West Michigan Street
Indianapolis

Althea Young
536 West 30th Street
Indianapolis

James M. Yount
4816 Kensington
Evansville

Mrs. Delores Yowell
5141 Kingsley Drive
Indianapolis